

AD-A212 373

DOCUMENTATION PAGE

Form Approved
OMB No. 0704-0188

1a. RESTRICTIVE MARKINGS N/A		2b. RESTRICTIVE MARKINGS N/A	
3. DISTRIBUTION/AVAILABILITY OF REPORT Unclassified/Unlimited		4. MONITORING ORGANIZATION REPORT NUMBER(S)	
5. NAME OF PERFORMING ORGANIZATION 108-89		6. NAME OF MONITORING ORGANIZATION US Army-Baylor University Graduate Program in Health Care Administration	
7. ADDRESS (City, State, and ZIP Code) AHS San Antonio, TX 78234 6100		8. ADDRESS (City, State, and ZIP Code) N/A	
9. NAME OF FUNDING/SPONSORING ORGANIZATION N/A		10. NAME OF FUNDING/SPONSORING ORGANIZATION N/A	
11. ADDRESS (City, State, and ZIP Code) N/A		12. ADDRESS (City, State, and ZIP Code) N/A	
13. SOURCE OF FUNDING NUMBERS PROGRAM ELEMENT NO. PROJECT NO. TASK NO. WORK UNIT ACCESSION NO.		14. SOURCE OF FUNDING NUMBERS PROGRAM ELEMENT NO. PROJECT NO. TASK NO. WORK UNIT ACCESSION NO.	
15. TITLE (Include Security Classification) ESTABLISHMENT OF A COMPREHENSIVE MILITARY MEDICAL SYSTEM DURING WARTIME IN EL SALVADOR: A RETROSPECTIVE VIEW			
16. PERSONAL AUTHOR(S) GARCIA, JUAN M.			
17a. TYPE OF REPORT FINAL		17b. TIME COVERED FROM 7/83 TO 7/84	
18. DATE OF REPORT (Year, Month, Day) 88/9		19. PAGE COUNT 103	
20. SUPPLEMENTARY NOTATION			
21. COSATI CODES FIELD GROUP SUB-GROUP		22. SUBJECT TERMS (Continue on reverse if necessary and identify by block number) Low Intensity Conflict (LIC)	
23. ABSTRACT (Continue on reverse if necessary and identify by block number) This paper was done to show the needs of the El Savador government to create a military medical system within there country.			
24. DISTRIBUTION/AVAILABILITY OF ABSTRACT <input checked="" type="checkbox"/> UNCLASSIFIED/UNLIMITED <input type="checkbox"/> SAME AS RPT. <input type="checkbox"/> DTIC USERS			
25. ABSTRACT SECURITY CLASSIFICATION N/A		26. NAME OF RESPONSIBLE INDIVIDUAL Major Leahy	
27. TELEPHONE (Include Area Code) (512) 221-2324/6345		28. OFFICE SYMBOL	

DISSEMINATION STATEMENT A
Approved for public release;
Distribution Unlimited

89 9 06 095

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ACKNOWLEDGEMENTS

I wish to express my appreciation to Colonel Melvin E. Modderman, my old reader, for his patience, prodding, and helpful suggestions. I also wish to thank Colonel Wayne B. Sorensen, my new reader, for his prompt review of this material. I especially want to thank my secretary, Mrs. Sarah J. Eldridge, U.S. Army Medical Department Activity, Fort Stewart, Georgia, for the typing, formatting, and proofreading of this lengthy document, in addition to fulfilling the numerous responsibilities of her hectic, full-time job. My appreciation is also extended to the members of the Medical MTT II, to U.S. Embassy and military personnel in El Salvador, Panama, and the U.S., and to the host-country nationals, without whom this gratifying experience never would have taken place.

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I. INTRODUCTION

Those who forget the past are destined always to repeat it.

-- Santayana

There might be an argument for doing nothing to help the government of El Salvador. There might be an argument for doing a great deal more. There is, however, no logical argument for giving some aid but not enough. The worst possible policy for El Salvador is to provide just enough aid to keep the war going, but too little to wage it successfully.

-- The National Bipartisan Commission on Central America

In late November 1983, this resident was asked to interrupt his Health Care Administration Residency at Brooke Army Medical Center in order to serve as Chief, U.S. Army Humanitarian Medical Mobile Training Team II which departed for El Salvador in February 1984. This 23-man medical team composed of 10 officers and 13 enlisted personnel, was to remain in El Salvador for approximately six months and not to exceed a total of 179 days. The team was a follow-on to a similar one stationed in El Salvador between June and December 1983. Since 1983, there have been a total of eleven teams in El Salvador. The last one arrived in the summer of 1988. Future teams are contemplated,

though in recent years we have been scaling down our efforts.

The mission of these Medical MTTs has been "to assist the Host-Country to develop and structure an Armed Forces Health Care Delivery System." (TAB A).¹ The medical mission in El Salvador is an ongoing one-of-a-kind effort to reduce the high levels of mortality and morbidity by improving military health care delivery in a highly stressful and hazardous, Low Intensity Conflict (LIC) insurgency setting. The role of the Army Medical Department in this type of scenario typifies a new and different function which deviates from the traditional medical mission of "support" and should, therefore, be regarded as an "operational" mission.² The frequency with which the Army Medical Department will assume this posture is anticipated to increase in the future because this type of health care is viewed as "the least expensive, least controversial, most cost effective, and has the highest pay-off of all instruments of foreign policy."³ Due to its potential value, it is extremely important that the nature and magnitude of our medical efforts in El Salvador be described so that others, who may later be called upon to fulfill similar tasks, may have a body of knowledge from which to draw, in preparation for carrying out their assignments.

The purpose of this research project is to serve as a descriptive study on the approach to and the evolving process of establishing a comprehensive military medical system for a country during wartime. It is designed to add to the body of knowledge of our military medical efforts in El Salvador by

combining some of the lessons we have learned with a collection of documents which will serve as the most comprehensive, single reference source of our eight years of military medical involvement in El Salvador. The emphasis of the study is on the process, including our approach and accommodations to initial plans, rather than being an exhaustive analysis of the multiple problems, limitations, and deficiencies of their medical system.

The paper begins by providing a brief background profile of the country to include history, political situation, demography, foreign relations and relationship with the United States. This is followed by the circumstances which led to our presence there and by a description of the existing military medical conditions, characteristics, and resources. A brief description of the civilian medical establishment is also presented. This is followed by a discussion of the reasoning and rationale which led to the formulation of short, mid-term, and long-range goals. The accomplishments, problems, and implementation difficulties of the Med MTT I will be enumerated. A more detailed account of the Med MTT II will then be presented. This will include goals and accomplishments, problems and difficulties, and modifications to the original plans. Future plans and directions are then outlined. The study will finalize with personal observations, lessons learned, and conclusions.

This paper draws upon official information obtained from transmitted messages, surveys and reports; information papers, position papers, U.S. Department of State documents; newspaper

and journal articles, historical references, personal communications, and first-hand observations.

II. COUNTRY PROFILE

The more we learned, the more convinced we became that the crisis there is real, and acute; that the United States must act to meet it, and act boldly; that the stakes are large, for the United States, or the hemisphere, and, most poignantly, for the people of Central America.

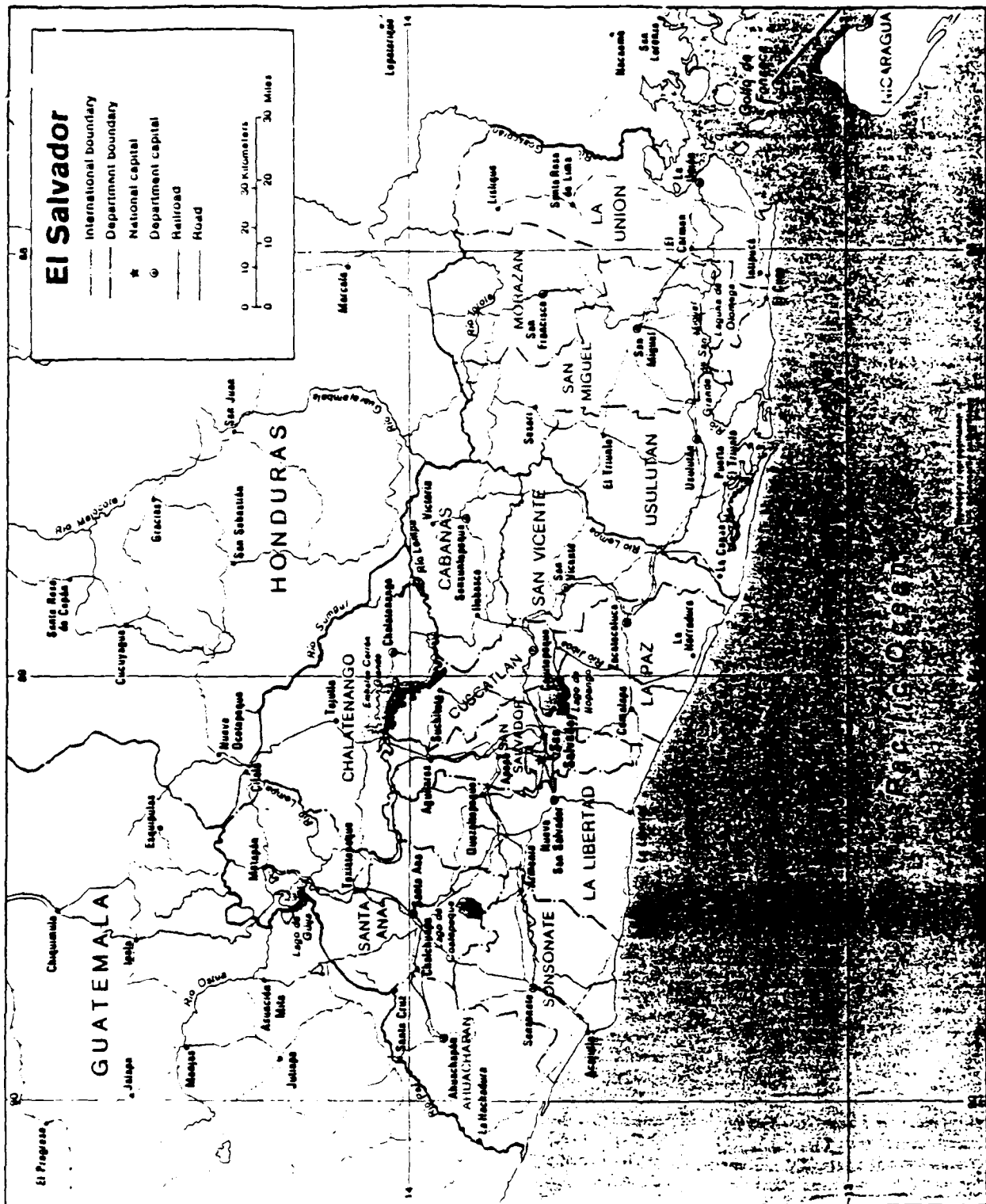
-- The National Bipartisan Commission on Central America

GENERAL

El Salvador is the smallest of the six countries located in Central America. Together with Guatemala, Honduras, Nicaragua, Costa Rica and Panama, this region is of profound political, military, economic, and social concern to the United States. It is bordered on the west by Guatemala, on the north by Honduras, and on the east by the Gulf of Fonseca, which separates it from Nicaragua. Its southern border faces the Pacific Ocean and, unlike other countries in the region, it has no outlet to the Caribbean Basin (Figure 1).⁴

Of interest is that El Salvador is only 1,890 miles from Washington, DC; it is closer to Washington DC than some of the eastern portions of the U.S. are to Washington. Commercial airline flights to Miami, Houston, and New Orleans from El Salvador take about two hours and twenty-minutes each.⁵

Geographically, El Salvador extends over an area of 21,476



¹ Source: From U.S., Department of State, Bureau of Public Affairs, Background Notes: El Salvador, February 1985, p.2.

square kilometers (8,260 square miles) and is roughly the size of Massachusetts.⁶ It is approximately 160 miles long and 60 miles wide.⁷ Its populational density of 595 per square mile is the highest in mainland Latin America.^{8,9} San Salvador, the capital city for over 400 years, is 2,240 feet above sea level.¹⁰ The capital grew in population by one million, from 400 thousand in 1979, to 1.4 million in 1984, primarily from the migration of poor refugees living in rural contested areas.¹¹

PEOPLE AND HISTORY

The population of El Salvador has been described as "remarkably homogeneous" with a breakdown into: 89 percent Meztizo (mixed Indian and Spanish extraction), 10 percent Indian, and one percent Caucasian.¹² There are extremely few blacks; invariably foreigners who either come to play professional sports or are part of U.S. military or embassy delegations.¹³ No significant minorities exist and the population is predominantly Roman Catholic with minor Protestant group activity throughout the country.¹⁴ Spanish is the official language although a small number of Indians have maintained their old customs, traditions, and language.¹⁵ The literacy rate is about 62 percent in urban areas and about 40 percent in rural areas.¹⁶ Fifty-eight percent of the population lives in rural areas.¹⁷ The population size is hard to estimate since there has not been a valid census since 1971.¹⁸ It was estimated to be 5.1 million in mid-1984.¹⁹

Historically, the country dates back to the 11th century, when the area was inhabited by Pipil Indians and was divided into two large Indian states.²⁰ At the time of the Spanish Conquest in 1525, there was a highly advanced flourishing Mayan civilization with imposing temples and elaborate cities. An estimated 300 pre-Columbian sites existed throughout the country.²¹ The Spaniards were successful in first bringing the area under the control of the Captaincy General of Guatemala in 1525, after an unsuccessful attempt to do so the year before. This control lasted until 1821 when El Salvador and other Central American provinces declared their independence from Spain.²²

Fearing incorporation of the region under the Emperor of Mexico in 1823, El Salvador petitioned statehood to the U.S. Government, following a defeat to Guatemalan troops which had been dispatched to enforce Salvadoran compliance. Shortly after, a revolution deposed the Emperor and the new Mexican Congress allowed that the Central American region be allowed to determine its own fate. In 1823, the Central American states formed the United Province of Central America. El Salvador became an independent republic when this alliance dissolved in 1838.²³

El Salvador enjoyed relative domestic tranquility until 1932. During this period, the country was controlled by a small number of wealthy landowners known as the "Fourteen Families."²⁴ In 1932, a peasant uprising against this oligarchy was led by Agustin Farabundo Marti, a communist leader trained in Mexico. The uprising was brutally quashed by then president, General

Maximiliano Hernandez Martinez, and between 10,000 to 30,000 peasants were massacred.²⁵ These two leaders have retained their historic significance. Farabundo Marti is the name under which the main fronts of the left-wing, revolutionary Marxist movement rally today. General Hernandez's name has been given to one of the right-wing vigilante "death squads," purported to have killed thousands of left-wing or moderate elements in recent years.²⁶

The almost 50 years following the peasant uprising were ones of relative calm and stability. The country was ruled by a succession of military leaders, elected by formality, in partnership with the economic elite. At times, the transfer of power was accomplished by bloodless coups.^{27,28} In July 1969, El Salvador and Honduras engaged in a brief and bloody war known as the "Soccer War," "Five Day War," or the "100-Hour War." The underlying issues were unresolved border disputes with Honduras and the emigration of some 300,000 Salvadorans across the border. The conflict was sparked by a series of soccer matches which aroused nationalistic sentiments. Through intervention by the Organization of American States, a cease fire was achieved, and a "pacification zone" was established. This led to a means of resolving border disputes, which was finally agreed upon by both countries, in a treaty signed in 1980.²⁹

In 1972, the three-term mayor of the capital, San Salvador, Jose Napoleon Duarte, ran for the presidency and won by plurality. He was not allowed to take office, was beaten

severely, and was violently forced into exile to Venezuela by the Army.^{31,32} Toward the end of the 1970's, there was mounting social discontent, and political turmoil led to outbreaks of guerrilla warfare in the countryside and terrorist attacks in the cities by radical leftist groups. This prompted retaliations and executions from rightist "death squads."³³ In October 1979, young military officers joined forces with civilian leaders and deposed presiding General Carlos Humberto Romero. They replaced him with a five-man military-civilian revolutionary junta.^{34,35} This coalition allowed Duarte to return from exile in 1980, made him a member of the junta, and it appointed him to preside it a year later.³⁶

The revolutionary junta was "committed to profound social and economic change, respect for human rights, and democracy."³⁷ The junta reigned until March, 1982, when a constituent assembly was elected. It made widesweeping reforms that sparked further controversy between the left and the right. These included a three-phase land reform, a banking reform, and the nationalization of coffee and sugar foreign marketing exports.³⁸ It also made possible the resurgence of political parties with goals towards free elections.³⁹

The constituent assembly, a multipartisan, 60-member body was elected in 1982 by an overwhelming outpour at the ballots. It peacefully transferred power to Alvaro Magana as the provisional president.⁴⁰ The assembly's main purposes was to draft a constitution for the country and to schedule presidential

elections in 1984.⁴¹

Presidential elections were conducted in March 1984, and a run-off election between the two front runners was held in May 1984. In the run-off election, Duarte defeated Major Roberto D'Aubuisson, a former military officer, who had been heavily implicated in "death squad" activities. The turnout for these elections was in excess of 80% of the eligible voters. President Duarte won by 54% of the popular vote, and was installed in June 1984 for a 5-year term. He is the first constitutionally elected president of El Salvador in over 60 years.⁴² These elections and inaugural ceremonies took place while Medical MTT II was in country.

ECONOMY⁴³

The last decade has witnessed a devastation of El Salvador's economy. Between 1960 and 1978, the Gross Domestic Product (GDP) rose rapidly from \$2.0 billion to \$5.3 billion. Following the outbreak of internal hostilities, the GDP fell between 1979 to 1982, by 25 to 30%, to \$4.07 billion. During this period, the per capita income has only increased from \$650 per year (1978) to \$854 per year (estimate for 1984). The economic growth rate averaged a steady 5% between 1970-78. It declined sharply from 1978 to 1982, and was estimated at a modest 1.5% for 1984. The Defense budget rose from 12.6% in 1979 to 23% in 1984. Economic aid from the U.S. rose from \$99 million in FY 1981 to \$329.3

million in FY 1984. The inflation rate has declined to 13% in 1984 from a high of 30% in 1980. This marked decline in the economy has been primarily attributed to damages inflicted by guerrilla forces who have vowed to destroy it by attacks and sabotage on agriculture, commercial transportation, roads and bridges, industry, telecommunications, and power plants. The damages amount to estimated losses of \$1 billion. The domestic violence has also led to sharp declines in foreign investment, to capital flight, to interference with production and exports, and to reduced public and private investments. The sharp increases in oil prices, between 1979-80, also had significant effects. Unemployment and underemployment have been estimated at 40%. In 1983, the economy was calculated to be three-quarters of the size it was in 1978 and the per capita income at the level of the early 1960's.⁴⁴

Another significant factor which has affected the economy has been the radical, but slowly marching, redistribution of wealth through land reform. Under Phase I of this plan, all properties of over 500 hectares (1,235 acres) were expropriated by the government and turned over to some 317 cooperatives benefitting an estimated 188,000. Phase II called for the selling of properties in excess of 245 hectares (600 - 1,235 acres) to small farmers. Phase III required the leasing or renting of sharecroppers' plots of up to 7 hectares (17.3 acres), an estimated 8% of the total farmland, to benefit approximately 364,000 people. Despite many problems, this initiative is

expected to have a long term benefit on the economy. El Salvador's economy relies heavily on agriculture (20% of GDP) and industry (16% of GDP). Major agricultural products include coffee, sugar, livestock, corn, poultry and sorghum. Industrial products include food and beverages, textiles, footwear and clothing, chemical products and petroleum products.

Exports between 1980 and 1983 declined by 27% and imports by 10%. Coffee accounts for 54.6% of exports. The U.S. is the principal trading partner accounting for 35% of purchased exports and provided imports. Other major trading partners include the Central American Common Market, European countries, Japan, and other Latin American countries.

Due to the marked decline in the Salvadoran economy, substantial aid has been obtained from the International Monetary Fund, the Inter-American Development Bank, the World Bank, the Export-Import Bank, the U.S. Agency for International Development, and U.S. Security Assistance and Foreign Military Sales programs.⁴⁵

DEFENSE

The El Salvador Armed Forces (ESAF) have increased significantly in numbers since 1979. The estimated armed forces manpower in 1984 were 31,000: Army, 30,000; Air Force, 500; Navy, 500. The three police forces had an estimated additional 10,000 for a total of 41,000. Insurgent forces were estimated to be in the vicinity of 9,000 - 11,000.⁴⁶

Training of soldiers has traditionally been the responsibility of individual battalion and brigade commanders. In recent years, on-site assistance from military advisers, totalling 55 within the U.S. Military Group (USMILGP), has been available. Several elite Salvadoran battalions received training in the United States. Helicopter and other aircraft pilots also received training individually in the U.S.⁴⁷

Efforts were underway to establish a National Training Center in La Union province by late 1983. Limited unit training also took place at the Regional Military Training Center in Honduras alongside Honduran troops. Officer candidate training took place at the four year military academy in San Salvador, known as the Escuela Militar Capitan General Gerardo Barrios. Graduates of this academy belong to tight-knit peer groups or "tandas" upon which promotions were typically made. In the 1950's and 1960's, each graduating class was comprised of 12 to 20 officers.⁴⁸ Efforts were in progress to change promotions to a "merit" system in addition to seniority. Significant strides have been made in developing the armed forces into an effective fighting force.⁴⁸

FOREIGN RELATIONS

El Salvador has traditionally enjoyed warm and cordial relationships with the United States. It is a member of the Organization of American States and of the United Nations. The Headquarters for the Organization for Central American States is

located in San Salvador. El Salvador plays a very active role in the Contadora Process which was established to promote peace and stability in the Central America region.⁵⁰

The United States has pledged its support to El Salvador in their efforts to democratize the country, improve human rights conditions, promote economic growth and stability, and defend itself from internal and external communist insurgency. In 1981, Congress passed the International Security and Development Cooperation Act. It states that "peaceful and democratic development in Central America is in the interest of the U.S." and that "substantial economic assistance to El Salvador is necessary to help alleviate suffering and promote economic recovery within a peaceful and democratic process." This assistance was contingent upon observation of human rights, a controlled military, economic and political reforms, and holding of elections at an early date.⁵¹

CONCLUSION

El Salvador's remote history, roots, culture, traditions, and make-up shed ample light on the recent turmoil and political upheaval which this country is undergoing. It is as if a nation with a past history of violent nightmares were experiencing a rude awakening. From its formative years, El Salvador has had a history which is studded by violence and explosivity. Its people are proud, defiant and courageous. Their past portrays a

struggle between forces trying to obtain and control and those fighting subjugation. This struggle has manifested itself externally, with their neighbors, and internally, among its social classes and elites.

For more than forty years following the peasant insurrection, the country enjoyed a period of relative peace and stability through a succession of military dictators. In the late 1970's, the picture changed dramatically. The long standing, dangerous configuration of historic poverty, social injustice, and closed political systems common to many of the Central American countries, was aggravated by economic recession and accentuated by foreign communist insurgency support.⁵²

The magnitude of discontent might be gleaned from economic figures which indicate that in 1980, the richest 20% of the population received 66% of the national income, whereas the poorest 20% received only 2%.⁵³ Similarly, between 1978-79, 86% of investment in housing was for dwellings for the top 20-25% of the income range.⁵⁴

One of the key elements which led to profound social unrest and upheaval has been attributed to the clerical leadership of some members of the Catholic Church. The Jesuits University, (UCA, or "La Universidad Centroamericana Jose Simon Canas,⁵⁵) openly promulgated their views on "Liberation Theology." This doctrine emerged from the Second Vatican Council, Historic Bishops Conference in Medellin, Colombia in the 1960's. It regarded as appropriate, the duty of the Church "to bring about

social change, even violent change . . . when reason failed.⁵⁶ Under this rubric, it was proper to take up arms in order to fight oppression and promote social justice. The university became a hotbed which harbored and trained communist sympathizing leadership. They found fertile ground among the peasants in the countryside. With this influence, coupled with financial and military aid from Cuba and Nicaragua, communist insurgents managed to establish a foothold which partially succeeded in bringing the Salvadoran economy to its knees and spreading violence and fear.^{57,58}

In response, the ultra-conservative militarily controlled right wing entrenched itself in an attempt to stamp out the threat and maintain the status quo. This led to further repression and abuses from security forces and violence from the alleged right wing death squads. Some believe that the lawlessness of security forces is the result of the breakdown in the judicial system's capacity to deal with apprehended terrorists and wrong-doers because of intimidation.^{59,60}

Simultaneously, El Salvador is experiencing severe financial pressure from the United States to move towards democracy, improve human rights violations, and implement agrarian reform.^{61,62}

Simply stated, the Salvadoran political structure found itself in a situation where all the traditional ground rules had suddenly changed and where the elements in power were facing demands from the insurgents, the reactionaries, and from its

democratic allies. These opposing forces are pulling the country in different directions. The nation's present plight is one of adaptation and survival.

From a United States perspective, our concerns were clearly and eloquently stated by the Bipartisan Commission on Central America:

"...indigenous reform, even indigenous revolution, is not a security threat to the United States. But the intrusion of aggressive outside powers exploiting local grievances to expand their own political influence and military control is a serious threat to the United States, and to the entire hemisphere"⁶³ . . . "What gives the current situation its special urgency is the external threat posed by the Sandinista regime in Nicaragua which is supported by massive Cuban military strength, backed by Soviet and other East bloc weapons, guidance and diplomacy, and integrated into the Cuban network of intelligence and subversion."⁶⁴

III. CIVILIAN HEALTH CARE DELIVERY

. . . We have a humanitarian interest in alleviating misery and helping the people of Central America meet their social and economic needs, and together with the other nations of the hemisphere we have a national interest in strengthening democratic institutions wherever in the hemisphere they are weak.

-- The National Bipartisan Commission on Central America

In October 1985, Nichols described in considerable detail, the health care delivery system of El Salvador. His assessment was funded by the U.S. Agency for International Development and was based on a site visit from 13 to 25 August 1984.⁶⁵ Briefly summarized, the Health Delivery System has five major components, namely: Ministry of Public Health, Salvadoran Social Security Institute, National Administration of Telecommunications, Teacher Health Program, and the Military Health System.

By far the largest is the Ministry of Public Health and Social Assistance (MSPAS), which is funded by the government and serves 85 percent of the population with direct care delivery and public health protection. It operates 14 hospitals in the five regions of the country. The system also incorporates 12 "health centers" 98 "health units," 164 "health posts" scattered throughout the country, and various "community posts" in urban areas. Though regarded as more advanced than those of other

developing countries, the system was regarded to be critically short of pharmaceuticals, equipment, supplies, vehicles, training and delivery of emergency medical services.

The Social Security System (SSS) is the largest nongovernmental, private agency for public health and welfare in the country. It operates seven hospitals and 38 "health centers." Though better budgeted, its funding is hampered by high levels of national unemployment.

The Telecommunications Health System (ANTEL) and the Teachers Health Program (Bienestar Magisterial) play relatively minor roles in the nation's comprehensive health picture.

The country's emergency medical services were assessed by Faich and Coppedge, between April and May 1983, under a U.S. AID grant.⁶⁶ This study pointed to a generally good cooperation between the civilian and military care systems, high rates of civilian trauma casualties, delayed and crude first aid and treatment, inadequate patient transport, poor training of emergency personnel, scarcity of surgical manpower, and limited rehabilitation facilities. In spite of the informal cooperation between civilian and military facilities, there is some reluctance on both sides to place soldiers in civilian facilities. The civilians fear reprisals from terrorists and guerrillas. The military is uncomfortable because of the lack of security against attacks and the perception that some civilians are sympathetic to the insurgents' cause.⁶⁷

There is a significant maldistribution of skilled medical

personnel throughout the country. This stems from the reluctance of physicians and nurses to serve in contested areas of significant guerrilla activity, for fear of being captured and forced to provide care to insurgents. This fear is based on a few instances of kidnapping and injury, although there is lack of factual evidence to substantiate the validity of this perception.⁶⁸

With regards to physicians, it is estimated that the country has approximately 28,000, half of whom worked for the Ministry of Public Health in 1983. Until 1980, the main sources for training of medical students was the National University. On June 26, 1980, the military overpowered and closed the university because of communist inspired unrest. Subsequently, four additional medical schools opened and the National University Medical School reopened in 1983. It is anticipated that physician shortages will not be significantly reduced until the late 1980's.⁶⁹

There are two types of nursing personnel. Those fully trained number approximately 1500, and are educated in three nursing schools belonging to the Ministry of Public Health. There are twice as many nurse auxiliaries, who are trained at these nursing schools, and within several other programs. While nurses are in adequate supply, there is an undersupply of nurse auxiliaries. As with physicians, maldistribution favors supply to metropolitan, noncontested areas. The maldistribution problem, however, is not as dramatic as for physicians.⁷⁰

In summary, the civilian health care delivery system is underfunded, undermanned, undertrained, maldistributed, and inefficient. The military hostilities have markedly diverted funding and personnel resources in support of the war effort.

IV. MILITARY MEDICAL SYSTEM

Perhaps the United States should have paid more attention to Central America sooner. Perhaps, over the years, we should have intervened less, or intervened more, or intervened differently. But all these are questions of what might have been. What confronts us now is a question of what might become. Whatever its roots in the past, the crisis in Central America exists urgently in the present, and its successful resolution is vital to the future.

-- The National Bipartisan Commission on Central America

BACKGROUND

U.S. military medical involvement in El Salvador dates back to July of 1980 (TAB B).⁷¹ At the request of the Government of El Salvador, a three-man medical team of U.S. Army officers was dispatched on August 12, 1980, to assess El Salvador's military health care system and to provide recommendations for its improvement. Headed by COL Hernan Morales, Medical Corps, the team remained in country for 15 days. During their stay, they were to determine training requirements for corpsmen in support of field troops, as well as training requirements for improvement of hospital administration and medical supply functions. They were also tasked to define any other unspecified training requirements for improvement in the military hospital and in

field medical services. The team was to also determine requirements for medicines and equipment. In their survey, the team conducted extensive personal interviews with numerous key personnel, conducted on-site visits, and collected available reports and selected workload and statistical data. They provided a general description of the military health care system and a specific description of the military hospital, the medical company, the medical logistical system and other features of the system. The medical survey team identified multiple problem areas and provided extensive recommendations for improvement of the various components of the system they evaluated. They also proposed the establishment of a consolidated Health Services Directorate and outlined the organization and functions of its component elements.

There was no further formal U.S. military medical involvement until March of 1983, when the Commander of the U.S. Military Group in El Salvador requested an assistance visit from the Commander in Chief, U.S. Army Southern Command (USSOUTHCOM) in Panama (TAB C).⁷² On March 20, 1983, a three-man team was dispatched from USSOUTHCOM for six days to provide the Commander, USMILGP El Salvador, with short and long-range recommendations for improved treatment of casualties resulting from wounds and illness related to the conflict. Although the team may have had knowledge of the 1980 Medical Team Survey, it appears that they were not in possession of the team's lengthy after action report, since it was not listed among the five references cited. During

their visit, the SOUTHCOM team made field site visits to a number of contested areas, toured military and civilian field and fixed facilities, and interviewed key personnel in the medical system. Although much briefer, their report defined many of the previously reported problems and outlined many of the same recommendations. These included the lack of basic equipment and supplies, the profound lack of training for casualty care, the deficiencies of the medical support system, the absence of adequate sanitation, and the need for an effective evacuation system, particularly by air.

Shortly after this assistance visit, the problems of El Salvador's military medical problems were elevated to White House attention in March - April 1983 (see TAB B-1).⁷³ On May 23, 1983, President Reagan directed that a U.S. Army Humanitarian Medical Mobile Training Team (MED MTT) be sent to El Salvador at the earliest. Two days later, COL Morales, the new MED MTT Chief, who had conducted the 1980 Medical Survey, departed with another member of an Advance Party to El Salvador. Following a rapid assessment of the situation, a 25-man MED MTT was assembled and oriented at Fort Sam Houston, Texas. On June 26, 1983, they arrived in El Salvador for a tour not to exceed 179 days.

MILITARY HEALTH CARE SYSTEM

In 1980, Morales provided an accurate description of the military medical system.⁷⁴ The organizational features and

limitations he pointed out remained essentially unchanged. When the Medical MTT I arrived in June 1983, if anything, conditions had deteriorated over the subsequent three years, as a result of the financial hardships and stepped up violence resulting from sustained and unmitigated escalation of wartime efforts.⁷⁵

The old Military Hospital in San Salvador was, and is still the heart and hub of the military medical health care system. Loosely attached was the coordination with 44 troop medical dispensaries (infirmaries) in autonomous, dispersed, garrisons and installations. The National Guard, the Treasury Police (Hacienda), and the National Police also had smaller infirmaries in some of these headquarters and installations. The Salvadoran Air Force had an infirmary at Ilopango Air Base. Invariably, these treatment facilities were understaffed, unsanitary, ill-equipped, and staffed by well-meaning, dedicated, but poorly trained medics. Physician coverage was provided by civilian contract physicians who conducted sick call two-to-three times per week for a half-day. They took very little interest in the training of medical personnel or the upgrading of equipment and quality of care. Front-line medical care was virtually nonexistent. Care provided to combat casualties was done so by poorly trained, underequipped, and misutilized medics, frequently assigned to combatant roles. Inadequate and delayed initial treatment, poor evacuation capabilities, and delayed definitive treatment led to an alarming rate of deaths of casualties due to exsanguination or infection. Delays in definitive treatment of

24-to-72 hours were not uncommon. Casualty transport in private vehicles over muddy, guerrilla infested roads was commonplace. Absence of immediate intervention and aeromedical evacuation was the norm.

In mid-1983, the Military Hospital remained the center of all significant military medical activity regarding planning, decision making, education, training, definitive treatment, and logistical resupply of the outlying dispensaries. The director of the Military Hospital reported directly to the High Command (Estado Mayor). The hospital housed the policy-making, key medical personnel which consisted of eight commissioned military physicians, three military dentists, and six commissioned military nurses. A few physicians were in training abroad.

In February 1984, staffing consisted predominantly of some 170 civilian part-time physicians (150 specialists and 20 general practitioners); approximately 60 civilian physician residents; some 400 nursing personnel, most of whom were auxiliary nurses and additional military and civilian ancillary personnel. A residency training program, and training programs for nurses and auxiliary nurses, were also in place.⁷⁶

The hospital was originally built in 1934. Over the years, it expanded gradually by occupying adjacent structures, such as the old nursing school, and converting them into hospital wards. Outpatient clinics, mental hygiene, and social work services were harbored in an adjacent building within the complex, which has been leased from the Salvadoran Cancer Institute. Between 1979

and 1983, hospital beds increased from 90 to 400. Construction of additional floors and buildings, and emplacement of temporary buildings and shelters, turned the hospital complex into a crammed compound of modestly new and old buildings in various stages of dilapidation. Parking space was extremely limited and entrances were guarded by armed soldiers and security personnel. Halls, wards, offices, and treatment facilities were packed with people. Hospital personnel appeared to be quite busy. The new Military Hospital construction in San Salvador began in 1973. Originally, it was designed for 175 beds and was scheduled to open in 1982. When hostilities broke out in 1979, and the casualty rate began to climb, construction was delayed in order to expand bed capacity to 350 beds by adding additional floors. Construction design to provide for security was also added. By 1982, the devastation of the economy, caused by guerrilla warfare and terrorist attacks, reduced funding available to complete the project. As unpaid debts to the contractors mounted, construction companies began to walk off the job. By 1984, less than 50 percent of the work force remained on the job.

In 1983, logistical and pharmaceutical resupply to the country's dispensaries, and to the military hospital, were under the control of the High Command (Estado Mayor). Some improvements in medical logistics at the Military Hospital had taken place as a result of recommendations from the 1980 Medical Team Survey.⁷⁷

MEDICAL SCENARIO⁷⁸

Between 1979 and 1983, the armed forces of El Salvador had increased from 12,000 to 39,000. During this time period, the types of patients who received health care in the military medical system changed drastically. Instead of the traditional minor illnesses, obstetrical care, and motor vehicle accidents, the system shifted to accommodate for a large number of combat casualties, illnesses, and injuries resulting from guerrilla warfare and terrorist attacks.

Field medical support was virtually nonexistent. Many medics previously trained for nine months in the Military Hospital were not functioning as combat medics. They had no equipment and were employed as infantrymen, machine gunners, and in other endeavors. They averaged a 6th to 8th grade education.

The garrison dispensaries were ill-equipped to handle the increasing numbers of combat casualties and illnesses. There were marked shortages in personnel and the available staff was not properly trained and organized.

Medical evacuation by air was, for the most, nonexistent. Some casualties and cadavers were transported by helicopter gunships during back-haul following combat operations. Ground evacuation was inadequate and limited. Casualties might be transported in World War II vintage 1/4 ton ambulances, in pickup trucks, or in larger trucks. Movement of casualties by ground was hazardous because roads were very guerrilla-infested.

Demolished bridges and muddy roads made certain roads impassable.

These factors led to delays of 4-to-24 hours for definitive treatment. Delays up to 72-hours after wounding were not uncommon. Mortality due to exsanguination or infection secondary to treatment delay was high. Definitive care took place primarily at the Military Hospital, where overcrowding, understaffing, and old equipment detracted from optimal care. In spite of these shortcomings, Table 3 shows a 97 percent survival rate once the casualty arrived at the hospital (see Tables 1,2,3).

Statistics for killed and wounded in action between July 1, 1981 and June 30, 1983 were obtained by MED MTT I, from figures released by the Minister of Defense to the media (Tables 1,2,3).⁷⁹ These figures show that between mid-1982 to 1983, as compared to mid-1981 to 1982, the number of killed and wounded in action had doubled. They also showed that deaths from wounds were approximately 33 percent. This contrasts sharply with a 10 percent mortality rate in Viet-Nam (1KIA: 9W1A). The magnitude of the progressive increase in the number of deaths over the past four years prompted the government of El Salvador to request U.S. assistance to improve military medical care.

In July 1984, our MED MTT (II) obtained revised figures from the Estado Mayor for Calendar Years 1982, 1983, 1984 (Table 4).⁸⁰ These figures show an even higher mortality rate for 1983 and the first six months of 1984 at 41 percent.

TABLE 1
SALVADORAN ARMED FORCES CASUALTY FIGURES

CATEGORY	1 JUL 81 - 30 JUN 82	1 JUL 82 - 30 JUN 83	TOTAL INCREASE	PERCENT INCREASE
KIA	1,073	2,292	1,219	114%
WIA	2,484	4,195	1,711	69%
MIA	270	328	58	21%
TOTAL CASUALTIES	3,827	6,815	2,988	78%

¹Source: From Colonel Robert F. Elliott, Memorandum for Secretary of Defense, 7 September 1983, subject: Medical MTT Objectives and MEDEVAC Requirements (TAB D-1).

TABLE 2

SALVADORAN ARMED FORCES CASUALTY RATIOS

PERIODS	KIA	WIA	¹ RATIO
1 JUL 81 - 30 JUN 82	1,073	2,484	1:2.3
1 JUL 82 - 30 JUN 83	2,292	4,195	1:1.8
2 YEAR TOTALS	3,365	6,679	1:1.98

¹ Based on U.S. Army Vietnam experience: 1 KIA to 9 WIA for all wounded evacuated to field hospitals. Dedicated MEDEVAC system primary reason for improved survival rate.

² Source: From Colonel Robert F. Elliott, Memorandum for Secretary of Defense, 7 September 1983, subject: Medical MTT Objectives and MEDEVAC requirements. (TAB D-1).

TABLE 3

SALVADORAN ARMED FORCES CASUALTY COMPARISONS
(KIA AND WIA INSIDE AND OUTSIDE MILITARY HOSPITALS)

PERIODS	DIED OF WOUNDS IN MILITARY HOSPITAL	DIED OF WOUNDS OUTSIDE MILITARY HOSPITAL	TOTAL DIED OF WOUNDS NATION-WIDE	% MORTALITY INSIDE: OUTSIDE
1 JUL 81 - 30 JUN 82	84	989	1,073	8%:92%
1 JUL 82 - 30 JUN 83	70	2,222	2,292	3%:97%

PERIODS	WOUNDED* TREATED IN MILITARY HOSPITAL	WOUNDED TREATED OUTSIDE MILITARY HOSPITAL	TOTAL WOUNDED NATION- WIDE	WOUNDED TREATED INSIDE: OUTSIDE
1 JUL 81 - 30 JUN 82	1,757*	727	2,484	63%:37%
1 JUL 82 - 30 JUN 83	1,896*	2,299	4,195	45%:55%

¹Many wounded were given initial care outside San Salvador; this number reflects those who were evacuated to military hospital.

²Source: From Colonel Robert F. Elliott, Memorandum for Secretary of Defense, 7 September 1983, subject: Medical MTT Objectives and MEDEVAC Requirements (TAB D-1).

TABLE 4

CASUALTY FIGURES			PERCENTAGE
82	KIA	1028	35%
	WIA	<u>2875</u>	65%
	Total	2903	
83	KIA	1348	41%
	WIA	<u>1980</u>	59%
	Total	3328	
84 Jan-Jun	KIA	556	41%
	WIA	<u>870</u>	59%
	Total	1363	

¹SOURCE

Figures obtained from the Estado Mayor in July 1984.

In September 1985, Meyer, a U.S. Army Reserve orthopedic surgeon serving as special consultant to the U.S. Army Surgeon General, described in detail the nature and extent of orthopedic injuries, treatment capabilities, and rehabilitation services. His observations were based upon an onsite assessment between August 13, 1985 and September 12, 1985, when he joined MED MTT V.⁸¹ Meyer pointed out the need for improvement in the treatment of spinal trauma and general orthopedic trauma, and the need for better prosthetic, orthotic and rehabilitation capabilities.⁸² He also commented on his amazement regarding the success of techniques which host-country orthopedic surgeons had developed.⁸³

V. MEDICAL MTT I

In sum, we believe that there is a chance for a political solution in Central America if the diplomacy of the United States is strategic in conception, purposeful in approach, and steadfast in execution.

-- The National Bipartisan Commission on Central America

MED MTT I was comprised of 25 members, and remained in-country between June and December of 1983. This MTT was the "pathfinder" and "ground breaker" in establishing relationships and credibility with the host country, the USMILGP, the U.S. Ambassador, the CINC USSOUTHCOM, and the high-level political and military U.S. agencies that had invested greatly in the success of this operation. While in country, it was under the microscopic examination of local and U.S. high-level political and military visitors and dignitaries to include the Vice President of the U.S., the Secretary of Defense, congressional delegations, the media, and a long string of others.

The accomplishments of MED MTT I are many, and are listed at TAB D-1.⁸⁴ The singularly most important contributions made by this group were the success of establishing themselves in an unknown, unfamiliar, and uncertain environment; working closely with host country medical officials to formulate mutually agreeable initial and rough short-term, mid-term, and long-range

objectives (Table 5) and establishing timetables for their implementation. These objectives served as a guideline and a template for successive MED MTTs now in their eleventh iteration. MED MTT I managed the expenditure of \$2 million in Foreign Military Sales.

The group was successful in establishing and spearheading significant training and equipment procurement initiatives. The main highlights for their accomplishments include:

1. Training of:

- * 380 Combat Medics
- * 46 Medical Service Officers
- * 20 Intensive Care Nurses
- * 5 Biomedical Equipment Repair Technicians

2. Translating of training material into Spanish.

3. Helped in designing and structuring the organization of the Medical Battalion.

4. Improvement of logistical support.

5. Procurement of:

- * Medical equipment for garrison infirmaries

TABLE 5

SALVADORAN ARMED FORCES MEDICAL OBJECTIVES

NEAR-TERM (1 JUL 83 - 31 DEC 83):

1. Establish medical command structure.
2. Establish Medical Service Corps and train MSC Officers.
3. Establish medical battalion (HQS and 4 companies).
4. Establish air MEDEVAC system.
5. Assimilate and train civilian physicians as Medical Corps Officers.
6. Train and equip combat medics.
7. Standardize and acquire aid bags and litters for combat medics.
8. Upgrade and equip unit dispensaries.
9. Improve sanitation in fixed facilities (infirmaries, dining halls, barracks, latrines, etc).
10. Conduct basic biomedical equipment repair course...
11. Establish hospital property book.
12. Establish medical library in Military Hospital.
13. Establish positions for battalion surgeons.
14. Upgrade and standardize nursing practices.
15. Develop job descriptions to include general and specific duties for Medical Corps and Medical Service Officers, registered nurses, LPNs, and enlisted medics.
16. Establish MOS system for medical personnel.
17. Standardize Battle and Disease/Nonbattle Injury (DNBI). reporting procedures.
18. Reprint medical references (FMs, TMs) in Spanish.

TABLE 5-Continued

19. Incorporate and develop new registered nurses for the ESAF as chief nurse/administrator and head nurses at proposed hospital sites.
20. Develop and use military medical specialists (LPNs and 6 month graduates) in military hospitals and infirmaries.

¹Source: From Colonel Robert F. Elliott, Memorandum for Secretary of Defense, 7 September 1983, subject: Medical MTT Objectives and MEDEVAC Requirements (TAB D-1).

TABLE 6

SALVADORAN ARMED FORCES MEDICAL OBJECTIVES

MID-TERM (1 JAN 84 - 31 DEC 84):

1. Establish Medical Field Service School.
2. Establish military ward in new San Miguel Civilian Hospital.
3. Provide medical training assistance to Salvadoran National Training Center.
4. Establish medical depot.
5. Conduct intermediate training for biomedical equipment repairmen.
6. Acquire ground ambulances for TOE medical units.
7. Plan and provide medical support for field operations.
8. Establish physical evaluation board (PEB).
9. Train and equip senior combat medics.
10. Upgrade surgical suites and intensive care units in the Military Hospital.
11. Establish military identification tag (name, service number, blood type, religion).
12. Streamline budgetary system for the Medical Command.
13. Develop TOEs for medical units.
14. Establish permanent position of Medical Advisor in USMILGP El Salvador.
15. Develop and equip a 10-bed intensive care unit in the Military Hospital.
16. Develop an immunization program for all Armed Forces personnel.
17. Develop medical records for all Armed Forces personnel.
18. Develop standards for each clinic, infirmary, ward, and hospital section.

TABLE 6-Continued

19. Conduct Host Country supply liaison visits to supported TOE infirmaries.
20. Develop annual medical progress report by calendar year.
21. Upgrade National Center for Physical and Occupational Rehabilitation.
22. Establish a National Humanitarian Assistance Coordination Group.

¹Source: From Colonel Robert F. Elliott, Memorandum for Secretary of Defense, 7 September 1983, subject: Medical MTT Objectives and MEDEVAC Requirements (TAB D-1).

TABLE 7

SALVADORAN ARMED FORCES MEDICAL OBJECTIVES

LONG-TERM (1 JAN 85 - 31 DEC 89):

1. Open new Military Hospital in San Salvador.
2. Reorganize old Military Hospital in conjunction with opening of the new Military Hospital.
3. Upgrade Rehabilitation/Convalescent Center in old Military Hospital.
4. Conduct advanced training for Biomedical Equipment Repairman.
5. Conduct Advanced NCOES for senior aidmen.
6. Provide specialized medical training for selected personnel in U.S. and Puerto Rico, i.e., Hospital Administration.
7. Establish medical personnel career progression program.
8. Develop an Intensive Care Nursing Program.
9. Develop a Nursing Rehabilitation Program.
10. Develop additional surgical (OR) nurses.
11. Establish a Veterans Administration.
12. Conduct a regular Civic Action Program for the civilian population when the Military Medical Service has structure, personnel and other resources.

¹Source: From Colonel Robert F. Elliott, Memorandum for Secretary of Defense, 7 September 1983, subject: Medical MTT Objectives and MEDEVAC Requirements (TAB D-1).

* Aidman bags and equipment for combat medics

6. Establishing aeromedical evacuation as a secondary mission for host country aircraft.
7. Stressing the importance of obtaining aeromedically dedicated helicopters.

VI. MEDICAL MTT II

. . . A great power can choose what challenges to respond to, but it cannot choose where those challenges come -- or when. Nor can it avoid the necessity of deliberate choice. Once challenged, a decision not to respond is fully as consequential as a decision to respond. We are challenged now in Central America. No agony of indecision will make that challenge go away. No wishing it were easier will make it easier.

-- The National Bipartisan Commission on Central America

PREPARATION STAGE

After a three-week delay, occasioned by funding uncertainties, our MTT arrived in country on 3 February 1984. The team was comprised of 10 officers and 13 enlisted who assembled at the Academy of Health Sciences, Fort Sam Houston, Texas on January 22, for pre-deployment briefings and preparations. Prior to deployment, the team received extensive security briefings. Orientations were provided by members of MED MTT I, some of whom were returning with our team.

Prior to departure, along with my logistics officer, I attended the Defense Institute Security Assistance Management five-day SAM-E Executive Course at Wright Patterson Air Force Base, Dayton, Ohio. I also had the opportunity to spend a three-day weekend at Fort Carson, Colorado, in-briefing with the team

chief of MED MTT I. Our team departed on commercial airlines via Houston, Miami, and Belize to Comalapa Airport in El Salvador. We were met by an advance party that had arrived days before and by members of the USMILGP. The team underwent in-processing, host-country orientations, security briefings and issuance of weapons and equipment.

COMPOSITION

The administrative element of MED MTT II consisted of a Team Chief, Deputy Team Chief, Sergeant Major, Administrative Sergeant, Supply Sergeant, and Clerk-Typist.

The training elements of the group consisted of:

* Combat Medical Support	7
* Aeromedical Evacuation	1
* Medical Logistics	1
* Preventive Medicine	3
* Biomedical Equipment Repair	2
* Medical Service Officer Development	2
* Advanced Nursing Care	1

REASSESSMENT STAGE

One of our first tasks on arrival was to review the initial plans and the accomplishments of MED MTT I. Next, we mapped out

broad areas which required involvement, and formulated more specific goals and objectives. Finally, we formulated long-range goals and objectives for emphasis in the subsequent 6 months after our departure (Table 8).

ACCOMPLISHMENTS

In general, Medical MTT II was highly successful in achieving the vast majority of the objectives it set for itself during our six months tour. The team efforts and many of the problems encountered are described extensively in our after-action report at TAB E.⁸⁵ Major contributions included the successful training of 362 combat medics, 30 MEDEVAC aidmen, 26 intensive care nurses, 26 medical service officers, and 8 biomedical maintenance repair technicians. Insistence and constant pressure resulted in securing and expediting the delivery of four restored UH-1H helicopters for dedicated aeromedical evacuation. These were delivered and assembled in June, 1984. Also dramatic, was our success in influencing high level host-country and U.S. policy decision makers. In May 1984, the Medical Battalion, which had been approved in concept in December, 1983, obtained its staffing authorization documents and was formally established on 1 June. We succeeded in having the Salvadoran Army Chief of Staff establish the Directorate of Military Sanitation as a separate entity, and to name the Salvadoran counterpart of our Surgeon General in June. Support from the U.S. Ambassador led to

TABLE 8

HUMANITARIAN MEDICAL MTT II

FEBRUARY - JULY 1984

IMMEDIATE GOALS

1. Reduce mortality and disability.

- *Train/Equip 380 Combat Medics
- *Train/Equip 30 MEDEVAC Aidmen
- *Train/Equip 25 Intensive Care Nurses
- *Obtain 4 MEDEVAC Helicopters
- *Obtain 44 Ground Ambulances
- *Establish ground evacuation system.
- *Train recruits in first aid at National Training
Center (La Union).
- *Re-equip El Paraiso dispensary.
- *Expand San Miguel dispensary.
- *Expand intensive care at Military Hospital.

2. Improve logistic and administrative structure.

- *Supervise functions of new medical battalion
- *Train 40 Medical Service Officers
- *Establish resupply for dispensaries and field units

3. Improve field sanitation.

- *Provide preventive medicine and field sanitation training to:

TABLE 8-Continued

- Recruits at National Training Center
 - Combat medics
 - Medical Service Officers
 - *Emphasize malaria prophylaxis
4. Coordinate and expedite delivery of donated medical equipment.
5. Expand medical library and improve journal access system.
6. Accelerate repair of biomedical equipment.
- *Train 5 Biomedical maintenance repair technicians
 - *Obtain better diagnostic equipment.
7. Improve medical administration.
- *Establish uniform operating/reporting procedures
 - *Establish individual personnel identification systems
 - *Establish field medical records system
8. Establish medical career incentives.
- *Obtain uniform-equipment pay for medics
 - *Enhance promotion and advancement opportunities for
Medical Service and Nursing Officers

¹Source: From Medical MTT II Working Documents.

TABLE 9

FOLLOW-ON HUMANITARIAN MED MTT III

AUGUST - DECEMBER 1984

GOALS

1. Open new Military Hospital (San Salvador).
2. Open Eastern Regional Hospital (San Miguel).
3. Prepare/plan Military Medical Civic Action Program.
4. Promote/stress recruitment and integration of civilian physicians.
5. Facilitate out of country training for:
 - *Physicians
 - *Nurses
 - *Medical Service Officers
 - *Biomedical Repair Technicians
6. Provide advanced training for medical noncommissioned officers.

¹Source: From Medical MTT II Working Documents.

incumbent President Magana's approval of \$10 million in funds for completion of the new military hospital. Through contacts in the Export-Import Bank, Ambassador Thomas R. Pickering secured a loan of an additional \$10 million to the Salvadoran government in order to re-equip and complete the construction of the new hospital. An urgent request to the Army Surgeon General's Office resulted in the prompt dispatch of a five-man Technical Assistance Team from the U.S. Army Health Facilities Planning Agency, to provide consultation for finalizing construction design and equipment lists for the new military hospital. Another \$100 thousand was obtained from the host-country Ministry of Defense for construction of the regional surgical hospital in the contested region of San Miguel.

Marketing and public relations initiatives led to contacts with the Air Commando Association and the World Medical Relief Organization. These efforts resulted in several shipments of donated medical supplies and equipment, totalling 78,000 lbs. and worth approximately \$4.5 million.⁸⁶ These were distributed among garrison dispensaries, the Military Hospital, and hard hit civilian towns. Separate coordination was made to obtain the delivery of a tractor-trailer van loaded with the contents of a 200-bed Civil Defense field surgical hospital, donated by Senator Ballinger from North Carolina, for the San Miguel region. Arrangements were made for interviews which resulted in favorable media coverage, which appeared in various U.S. newspapers (TAB F). High level U.S. military support allowed for the success of

the Salvadoran-hosted First International Medical Surgical Congress held in August, 1984, in which four senior U.S. Army and Air Force physicians and one civilian U.S. physician served as the keynote speakers (TAB G).

The team also made substantial contributions by improving the medical logistical system, improving sanitation and preventive medicine measures; by procuring \$800 thousand in medical supplies and equipment, and by obtaining medical textbooks from U.S. military medical treatment facilities and by obtaining donated journal subscriptions for the medical library of the Military Hospital. The team also saw the arrival of 10 of the 44 new ground ambulances.

During the last few weeks of the tour, the team chief and several team members of the MED MTT met almost daily with key host-country medical leaders, to deal with some urgent or unresolved issues. These included: establishment of the organization and functions of the office of the new Director General of Military Sanitation; recruitment and commissioning of civilian physicians; advancement and promotion system for military nurses, medical service officers, and enlisted medics; establishment of an effective malaria prophylaxis program; and development of individual identification measures, such as "dog tags," and of a field medical records system.

VII. PERSONAL OBSERVATIONS

For most people in the United States, Central America has long been what the entire New World was to Europeans of five centuries ago: terra incognita. Probably few of even the most educated could name all the countries of Central America and their capitals, much less recite much of their political and social backgrounds.

-- The National Bipartisan Commission on Central America

GENERAL

The nature of the insurgency setting in El Salvador and its attendant risks for U.S. military and civilian personnel imposed sharp restrictions on the access to many elements of the population and on the freedom to move around and mingle. Our interpersonal interactions were greatly limited to officers and soldiers within the military; to the civilian host-country nationals employed by the embassy; to civilians in higher social strata within the government and social circles with whom we came in contact; with servants and lower socioeconomic class people with whom we could safely come into contact; and with the masses we could observe from a distance. My personal impressions are based upon direct observations, anecdotal accounts, news media exposure, and indirect inferences.

THE PEOPLE

Compared to other ethnic groups to which I have been exposed, in general, the Salvadoran people and in particular, the low socioeconomic class, struck me as polite, courteous, humble, soft-spoken, somewhat unassertive, and even meek. I never witnessed a heated argument, a loud confrontation, or brash behavior. For them, it is important to avoid rudeness, to save face, and to avoid public embarrassment or humiliation. I was impressed by social class and status consciousness and the importance for people to be "in their place." Their history suggests that they have been subjected to harsh discipline, abuse, and oppression, which have often been brutal in nature.

They struck me as people who are bright, receptive, hard working, and eager to learn. By the same token, they seemed proud, courageous, and defiant people who are very capable of a high degree of violent behavior, particularly under the influence of alcohol. The heavy use of alcohol appears to be widespread. When drinking, the meek turn into "Supermen" and they vent their aggressions with their fists, machetes, and handguns. The possession of handguns and machetes is commonplace, and it is not unusual to see individuals with facial or body scars and amputations that have resulted from violent disputes. Shootings during arguments or fights are purported to be frequent. Likewise, spouse abuse, domestic violence, and an attitude of "machismo" are said to be prevalent.⁸⁷

THE MILITARY

The Armed Forces of El Salvador have been a stabilizing influence for the past 50 years. The Officer Corps is regarded as an "elite group" to which membership is earned after undergoing strict "rites of passage" and "paying dues," following attendance for four years at the Escuela Militar, our U.S. Military Academy equivalent. Classmates belong to a "tanda" or tight-knit year group which, rather than merit, is the basis for promotions. Some consideration has been given to incorporating promotion by merit but it has met with resistance. As members of an "elite group," some officers convey the impression that they are "entitled" to certain perks, privileges, and benefits which, by our standards, at times often constitutes graft and corruption.⁸⁸ Other officers are very conscientious and display marked integrity.⁸⁹ Compared to our military system, the Salvadoran military is rigid and authoritarian. There is much less delegation of authority and responsibility. Approval authority is withheld at the highest levels. There are only four rank distinctions among enlisted soldiers. Many of the functions which our noncommissioned officers execute are performed by cadet officer candidates and junior officers. There is a sharp rank consciousness, particularly among officers.

There is marked reluctance to commission civilian physicians as officers, since they have not attended the Escuela Militar, nor "paid their dues."⁹⁰ Likewise, civilian physicians are

suspect of being rebel sympathizers. During the 1969 "Soccer War," some civilian physicians were commissioned as officers, but this practice was soon abandoned. Only female nurses are commissioned into the military. By law, since they have not attended the Escuela Militar, they cannot be promoted beyond the rank of captain. As elsewhere, military physicians do not enjoy the status and prestige of combatant officers. Most have, however, been line officers before being sent to medical school. The MSC Officers we trained were an entity that had not previously existed in the Salvadoran Armed Forces. As such, they were subject to ridicule and had little opportunities for career advancement. They were sarcastically referred to as "Lieutenant Ointment," "Lieutenant Pill," or "Lieutenant Salve." This created a morale problem which prompted them to drop out shortly after beginning medical service officer training or to plan to branch transfer once their incurred obligation of service following training was met.^{91,92}

I heard remarks that, by our standards, Salvadoran officers have been noted to display a certain passivity, lack of "compulsivity," lack of punctuality, and slower pace.⁹³ I believe that to some degree, this might be due to cultural differences, but that it is predominantly due to stifling of initiative, and lack of risk taking in a system which tends to micromanage and discourages low level initiatives. Anti-American sentiment, although rumored, was not openly manifested. Our medics did report, however, that two field grade officers at the

San Miguel garrison, had expressed on several occasions their dislike for U.S. military personnel.

Nurses, though competent, assumed a subservient posture and were relegated to the physician "hand-maiden" status that our nursing profession rebelled against many years ago. Even ICU nurses could not initiate life-saving steps, for which we trained them, without prior physician approval.

One of the most striking features we observed was the resourcefulness with which the medical personnel tried to "make do" with what was available to them. This was evident in the way that they resterilized plastic disposable syringes, resharpened hypodermic needles, and wrapped towels around leaky WWII vintage autoclave sterilizers. They sterilized feminine sanitary napkins and used them as battlefield dressings for gunshot wounds.⁹⁴

THE STRESS

As might be expected, the amount of anxiety and stress endured by our personnel assigned on short notice to an high risk insurgency setting was considerable. Part of the stress was due to deployment into an unknown country with unfamiliar culture, language and food, and where the risk of death or serious injury or illness were significant.

In an effort to minimize the impact of the unexpected, a thorough pre-deployment orientation was conducted at the Academy of Health Sciences, at Fort Sam Houston, Texas during the two

weeks prior to deployment. This orientation included security and intelligence briefings, discussions with former team members, logistical preparations, travel arrangements, and time to put personal affairs in order. They were followed by additional security and intelligence briefs, a defensive driving course, and weapons familiarization firing, within the first few weeks in country.

Our conspicuous arrival on commercial jetliner into the crowded Comalapa Airport, was followed by a 45-minute ride in the late afternoon over deserted highways, through the mountains, into the crowded capital city of San Salvador. The trip ended upon arrival to the compound which serves as the headquarters and main house of the Medical MTT. It was affectionately known as "La Ponderosa."

La Ponderosa was a large, once beautiful, concrete, 30-to-40 year old, two story house which sits atop a 100-to-150 foot slope at the end of the driveway from the main gate. It is in a moderate state of disrepair and could have used some paint. The compound occupied an area about one-third the size of a city block. The yard had well kept lawns and many large trees, small bushes, flowering plants, and fruit trees. At night, the yard was illuminated from the roof by a number of floodlights. The compound was encircled by concrete and cyclone fences and high walls. The fences and walls were topped with concertina and barbed wire. The tops of the walls were encrusted with broken bottle glass. There were usually three host-country guards on

duty around the clock. The guards were armed with automatic weapons and shotguns. They are also members of the national police or national guard. They served as armed escorts on the vehicles to and from different sites.

For our group, the main house served as primary residence for 12 of the team members, and a live-in maid. The remaining 11 team members resided in three smaller houses in a housing area adjacent to the Estado Mayor, within a compound containing houses owned by field grade officers of the High Command. This compound was heavily guarded by Salvadoran soldiers, and enjoyed tight security. In all our houses, we kept M-16 automatic rifles, MP-5 sub-machine guns, sawed-off shotguns, grenades, and flares. Each team member also carried a 9mm side arm at all times. For each house, we developed and practiced security, defense, and escape plans.

During the week, approximately one-half of our personnel remained at the two remote training sites at the garrisons of San Miguel and San Juan Opico. At San Miguel, our medics shared a small house with cadet officer candidates. At San Juan Opico, they were billeted in small, two-man rooms. In these, as well as other remote sites which were regularly visited, living conditions were substandard and unsanitary. During weekends, team members would return to the capital.

At night, silence was regularly interrupted by the sounds of bombs exploding in the distance, and by automatic weapons fire, shotgun blasts, and small arms fire. As the elections and run-off elections approached in March and May respectively, power

outages, due to terrorist bombings of hydroelectric plants, were almost a nightly occurrence. During the day, we travelled the, at times, bumper-to-bumper traffic on congested streets in our unarmor-plated, easily detectable Jeep "Cherokee" vehicles. We were constantly on the alert for dangers posed by would-be pairs of terrorists on motorcycles as they approached our vehicles. We were frequently confronted by military or police roadblocks and checkpoints. The knowledge that we were possibly being observed or followed by persons we couldn't detect, but who knew who we were, made us hypervigilant and expectant. This was further accentuated when we were put on notice by the terrorists, close to election time, that they intended to capture and kill a high ranking U.S. military officer. Subsequently, a military officer from the MILGP had a "close call" when two carloads of men tried to box him in and ambush him one evening. He averted disaster by climbing his car over the sidewalk and speeding away. The possibilities of armor-plating our vehicles and installing bulletproof glass were considered. These ideas were discarded by the MILGP because it would cost \$25,000 for each of four vehicles and would take months to accomplish.

Stress was also increased by the accidental discharge of a "hair-trigger" shotgun within one of our vehicles; it blew a hole through its side. A shotgun had also accidentally discharged through the floor of a vehicle months earlier in the team prior to ours. Another shotgun was accidentally discharged in a bedroom of the house by one of our team members.

Those stationed in the San Miguel garrison, faced the added tension of guerrilla attempts, at night, to overrun the compound. Several attacks took place while they were there. On one occasion, our medics were involved in the lifesaving care to several seriously wounded victims of mortar attacks and small arms fire. One of our personnel, a Viet Nam veteran who had previously been wounded and captured during the Cuban Bay of Pigs invasion, suffered a stress reaction while at San Miguel and was returned to the U.S. During the last few months of our stay, military funding cuts led to reduced "blade time" for our helicopters. Consequently, we were unable to pick up our men and bring them back for the weekend. This added to their stress because they had to remain at San Miguel for two-week stretches on several occasions. Transportation on host-country aircraft had been prohibited because their helicopters had a secondary mission of transporting casualties and could, therefore, be diverted into combat or into heavily contested areas. These aircraft were also prime enemy targets and one had been blown up on a runway while attempting to take off. The use of ground transportation to and from San Miguel and other western provinces was extremely hazardous because of the guerrilla presence.

Stress was also accentuated when we had to involve ourselves with problems we had not anticipated. For example, two days after our arrival, we dispatched a two-man preventive medicine team for several days to La Union, the site where the National Training Center was being constructed. They were in need of

urgent consultation for on the spot correction of design flaws in the drainage of latrines and other wastage. This site had been overrun several times by guerrilla forces. Another area of involvement was that of the El Paraiso garrison. On New Year's Eve, a month prior to our arrival, the garrison had been demolished in a surprise attack. There were high numbers of killed, wounded, and captured. Our presence was required to correct sanitation and drinking water problems, during their efforts to reconstruct the garrison. This site required frequent visits and was located in the heart of a contested region.

Further tension was generated by feelings of loneliness, isolation, homesickness, confining security restrictions, and periods of boredom and inactivity. Concerns were added by the possibility of contracting physical illnesses in a geographic region where malaria, hepatitis, typhoid fever, rabies, and diarrheal diseases were hyperendemic. Additionally, Morales has pointed out the stress on the families of team members in the U.S. and the pressures they exerted to have their love ones return to the U.S. and not extend their tour of duty (TAB D-4).⁹⁵

VIII. LESSONS LEARNED

History and experience both teach that effective diplomacy requires the coordination of many elements. Incentives for progress are essential. So are penalties for failure. Often, friendly forces need to be bolstered by both economic and security assistance. Aggressors must be made aware that unacceptable behavior carries risks. They must also know that a different pattern of behavior can bring significant benefits.

--The National Bipartisan Commission on Central America

THE APPROACH AND PROCESS

U.S. military medical involvement in El Salvador has been a dynamic and continuously evolving process; the approach has been a systematic one. It began with a host-country request for help, which led to a systematic analysis of the existing medical system. The external environment, the needs and the requirements, as well as the internal features of their military medical system were carefully assessed. The approach to the design of the system was a heuristic one in which the available components were improved upon in hopes of optimizing it. This was followed by the development of a strategic plan with joint U.S. and host-country participation in which short-term, mid-term, and long-range goals and objectives were identified. Med MTT I began the implementation of measures to attain these goals and

objectives and to assess the impact of their presence and interventions on outputs and outcomes. These measures were aimed at developing a comprehensive military medical system to reduce mortality and morbidity, and to satisfy medical wartime requirements. The experience gained from our involvement served to provide information and feedback with which to modify the system and reassess priorities. The result has been the progressive refinement of a system that initially tackled the most urgent requirements and has settled down to deal with the less urgent ones. It has evolved from the simple to the more sophisticated. The focus has shifted from the lifesaving, acute, primary care of battlefield casualties to definitive care, rehabilitation, and preventive measures.

The peculiarities, idiosyncracies, features, assets, and capabilities of El Salvador were the driving forces which determined the nature of their needs. Though one might have preconceived notions of the optimal solutions which should be implemented, it is important to realize early that each country with which we get involved is different. There is no pat, neat, uniform, or boilerplate solution that we can apply, as an exportable kit, which will satisfy the heterogeneous needs of the countries we assist. It is extremely important that we meet those requesting help where they are at, that we recognize their unique needs, that we listen to them, that we form a partnership, and that we avoid a condescending or paternalistic attitude.

Early on, we realized that we not only had to help El

Salvador build up their military medical system, but that we also had to help them build up their capability to subsist independently as we decreased our own involvement. We approached our training and other activities with the aim of working ourselves out of a job. We trained instructors who could carry on the mission as we disengaged. We encouraged the establishment of mechanisms whereby they could conduct their own training and procure their supplies and equipment. Our efforts were aimed at "team-building." Rather than plunging in and conducting massive Medical Civic Action Programs (MEDCAPS) which, in cosmetic fashion, would bolster U.S. image, we felt that it was more important that we assist them, through training and supply efforts, so that they could conduct their own programs and gain the support, trust, and confidence of their people.⁹⁶

We learned that the original strategic plans were overly ambitious and optimistic, that progress was slower than anticipated, and that severe economic hardships caused further unanticipated delays.⁹⁷ We realized the need to continuously reassess our plans, "roll with the punches," and capitalize on targets of opportunity. Given these miscalculations, it is important that we realize that, in future endeavors, we run the risk of withdrawing our resources prematurely or of reducing the required critical personnel mass to a level which will not allow them to do the job.

By trial and error, and "fumbling in the dark," we learned how to be more effective in obtaining responsiveness from the

USMILGP, the chain of command, the U.S. Embassy, United States Army Security Assistance Latin America (USASALA), and USSOUTHCOM. Since U.S. military involvement in El Salvador was such a hot issue, it gained high visibility with the Administration, Department of Defense, Department of State, Congress, Joint Chiefs of Staff, Office of the Army Surgeon General, Health Services Command, the Academy of Health Sciences, and a variety of other agencies, public media, and interest groups. Frequent visits, contacts, or requests from them caused considerable confusion and misguided efforts on our part, to obtain assistance from entities who were not in a position to provide much help. It took time to sort out the channels through which we could obtain more rapid responses. The MED MTT works for the Commander, USMILGP, who in turn works for the Ambassador.⁹⁸ We spent a considerable amount of time responding to inappropriate requests, guidance, and directives from the USSOUTHCOM staff.

PREDEPLOYMENT INITIATIVES AND INTERAGENCY COORDINATION

In retrospect, our contributions to El Salvador's medical system have been remarkable, despite ourselves. Our identification and selection of personnel to perform this mission appeared to be low-priority, last minute, haphazard, and short-fused.⁹⁹ The literature on Low Intensity Conflict seems to indicate that our engagement in these types of operational missions has a higher probability of occurrence than our engagement in conventional warfare.^{100,101,102} If our national

security, prestige, and influence were as important for this mission as they are touted to be, it would have served as well to spend more time in selecting the people who could do the best job. Yet, our approach appears to have been more reactive than proactive.

First of all, a Spanish surname "does not a Spanish speaker make." Some of our people were chosen because, presumably, they spoke Spanish. Some, however, were functionally illiterate and inarticulate in Spanish. For some positions, it was absolutely essential that the team member possess sufficient language skills, particularly if the job called for teaching soldiers who spoke no English. For other positions, though highly desirable, Spanish speaking was not totally required. On our teams, we have had one-of-a-kind individuals who neither possessed the necessary technical nor language skills, and who had to be sent back to the U.S. It is extremely difficult to obtain prompt replacements during a time limited mission. These difficulties could have been avoided by early identification and pre-screening of prospective team members. It would also have been helpful to have had an identified alternate person for each member of the team, to serve as a backup replacement on short notice. This is especially relevant for instructors and for Spanish speaking helicopter instructor pilots. Efforts should be made to coordinate with Reserve Component units, particularly in Puerto Rico and Florida, to identify suitable Spanish speaking personnel.¹⁰³

Part of the language problem has to do with the fact that

although host-country personnel might have a fairly good command of English, they felt embarrassed to speak in front of personnel they out-ranked, and who might speak better English than they did. The Minister of Defense, for example, always employed a translator when dealing with U.S. VIPs in front of his officers although he was felt to have a fairly good grasp of English. We were fortunate in that most of the high ranking medical leadership had received some of their training abroad and spoke English quite fluently.

Approval of mission funds was a serious difficulty with which we had to contend. While the need for a smooth and prompt transition between the departing and follow-on teams was regarded as very important, there was a six-weeks gap between the first two teams. Our team's departure to El Salvador was postponed twice because of difficulties in securing high-level approval of funds. Our arrival in country was three weeks later than planned and, up to the very last moment, we were uncertain as to whether we would finally depart. Coordination at high levels needs to be improved.

Difficulty in high level coordination was also evident during attempts to obtain funds for payment of the four UH-1H MEDEVAC helicopters. I was personally involved in repeated long distance phone conversations with State Department officials in order to find a source from which we could get the helicopters. We finally obtained four suitably refurbished ones from Corpus Christi at a cost of \$11.8 million.

Considerable difficulties were also encountered in attempting to elicit cooperation from the U.S. Air Force, in order to transport from the mainland, a 200-bed Civil Defense field hospital and the transport of tons of medical supplies and equipment worth \$4 million, donated by two separate sources. The disagreements centered around who would foot the bill, and resulted in significant delays.

SECURITY

Security is another topic which deserves further elaboration. At the Academy of Health Sciences, Fort Sam Houston, Texas, we received excellent security and terrorism pre-deployment briefs presented by personnel from the Security Assistance Team Management Office of the U.S. Army John F. Kennedy Special Warfare Center, Fort Bragg, North Carolina. We also received excellent security and intelligence briefs at the U.S. Embassy in El Salvador. In spite of past incidents, and perhaps because of the nature of our mission, it does not appear that members of our team were prime targets. Had we been so, I do not doubt that it would have been relatively easy for insurgents to have done us harm. The main reason why we could have been easy targets is because we stood out and were easy to identify. This was due to the fact that one of El Salvador's idiosyncracies was the absence of blacks, except for those associated with the U.S. Embassy and the USMILGP. There are far more blond and blue-eyed European and Oriental business people in the country than blacks unassociated

to the U.S. This is not a commonly known fact among non-Salvadorans.¹⁰⁴ Outside of the U.S. Embassy and the Ministry of Defense guarded compounds, our unarmored and unshielded Jeep "Cherokee" vehicles would have been very vulnerable targets. They would have been easy marks for attacks in the bumper to bumper traffic and during the travels along the lonely roads to and from the airport and training sites. To minimize risks, we avoided establishing travel routines by varying our routes and time schedules. We were also armed at all times, observed the two-man rule, and avoided many public places such as movie theaters, bars, and nightclubs which were ruled "off limits."

MEDIA

We learned that media coverage by U.S. reporters reflected the unpopular sentiment, among some, concerning U.S. military presence in El Salvador. On a daily basis, we received a compilation of the various newspaper stories that were being printed in the mainland. On a weekly basis, we viewed videotapes of the TV news highlights aired during the previous week. We were impressed by the slanted and biased coverage of events that bore little semblance to what we were witnessing first-hand. This phenomenon was noted in an analysis of favorable vs unfavorable nightly news coverage performed by TV Guide.¹⁰⁵ Coverage of our team's efforts and items of military medical interest did not enjoy much newsworthiness. Nevertheless, we were able to obtain several favorable write-ups (TAB F).

DEDICATED AIR EVACUATION

Perhaps the most agreed upon observation, even prior to our presence in significant numbers in El Salvador, was the need for dedicated aeromedical helicopter evacuation.^{106,107,108} This need was viewed as particularly critical because of the lack of an effective ground evacuation system in isolated areas devoid of close treatment facilities where the roads were impassable, particularly in the eastern regions of the country. Compounding the problem was the scarce number of helicopters and pilots. Upon our arrival in country, there were 18 helicopter gunships. At times, only nine of these were operational. Our combat casualty training was viewed as just a measure for "buying time" until casualties could be transported to definitive medical treatment facilities. Aside from some civilian hospitals, no adequate facility was available except at the Military Hospital in San Salvador.

Even after we obtained the MEDEVAC helicopters, there were still a number of problems. There were insufficient helicopter gunships to escort the MEDEVAC helicopters into hot landing zones; there were not enough trained crews to man them; and, they remained under the operational control of the Commander of the Salvadoran Air Force. The turf issues and fights over who controlled these assets were not dissimilar to some of the jealousies we experience with regards to control of aircraft assets. Consequently, dedicated MEDEVAC helicopters were not

utilized as frequently and as far forward as we have customarily employed them, and evacuation efforts were not as timely.

TEAM CHIEF ROLE

In looking back at our experiences in El Salvador, four years after the fact, the most important lesson I learned was that of the role to be assumed by the team chief. I have pondered and reminisced over the years about what I regard and treasure as an invaluable personal opportunity and experience.

I was thrust into the position of team chief on a relatively short notice of two months. The guidance I received was rather broad and vague in nature.

I was to take charge of a group of two dozen men performing a one-of-a-kind mission in a highly stressful and hazardous insurgency setting with which I was totally unfamiliar. I anticipated my departure with considerable apprehension and uncertainty, yet with a great deal of excitement and sense of challenge. By far, the most important lesson I derived was that of learning to effectively use the tremendous amount of power, clout, influence, and leverage that the position carried, in dealing with the host-country military leadership, with the U.S. military and political structures and decision makers, and with members of our own team. As the "on the ground" medical expert, I had the vast responsibility of "calling the shots" as I saw them and of providing guidance, direction, and advice to important key players and prime movers. It took a while for me

to realize the extent of my influence and the ability to bring about change.

Fortunately, I had decided early on that it was extremely important that I involve myself as closely as possible with the Salvadoran Minister of Defense, with the Armed Forces Chief of Staff, and with the host-country military medical hierarchy. I also developed close ties with the Commander of the USMILGP, with the U.S. Ambassador and embassy personnel, and with staff members at USSOUTHCOM Headquarters in Panama. Our effectiveness would have been sharply curtailed had I not had access and influence within these political and high level spheres. As the tour unfolded, it became apparent that the job required a great deal of tact, diplomacy, and ability to articulate our views accurately and convincingly.

Particular care must be taken in order to not be seduced into taking sides in internal squabbles. When the Director General of the Medical System was named, I was visited by two of the highest ranking officers with the medical leadership, who requested that I intercede. They wanted me to tell the Salvadoran Armed Forces Chief of Staff that the selection of the Director General was a mistake, and that he should be removed.

It is extremely important that the person serving as team chief be able to maintain perspective, be able to see the "big picture," and be able to "think big." I believe that, particularly in the early stages if not throughout, the team chief should be a senior physician with experience in executive

medicine positions or high-level operational medicine assignments. These requirements are dictated by the nature of the mission and the complex role the leader must play. Why this is so, did not become clearly apparent until much after I returned home.

The military medical scenario in El Salvador is a veritable playground or laboratory where there are so many tasks to be done, that the chores seem never ending. When plunged into a system with so many demands, our immediate inclination is to occupy ourselves by doing those things that we know how to do best, be it in the clinical or administrative arenas. As creatures of habit, and in order to feel useful, it is very easy to succumb to the temptation of carving out for ourselves, jobs in which the tasks are familiar. If we do so, we run the risk of seriously misdirecting our efforts.

One of the prime functions of the team chief is that of a spokesman; not only for the team and for the U.S. military, but surprisingly, for the host-country medical leadership. This fact became evident 16 months after I had finished my tour.

In November 1985, while at a U.S. federal medicine meeting in Anaheim, California, I had a chance to meet with the Director General of El Salvador's Military Sanitation (Surgeon General) who was simultaneously, the Director of the Military Hospital.¹⁰⁹ I had been somewhat instrumental in his appointment to the position and we had enjoyed a warm, friendly relationship. During the few hours we spent together, he related to me that one

of the problems with which the Salvadoran medical leadership had to contend was one of credibility with their own Estado Mayor. He verbalized the need to have U.S. medical support that could vouch, validate, substantiate, and provide credibility in support of their own positions, ideas, and recommendations. He further added that the then current team chief, an MSC logistician, whom he liked and regarded as competent, did not enjoy credibility among the physician leadership and the Estado Mayor, because of the fact that he was neither high ranking enough nor a physician.

This was very understandable in view of the system's rank and status consciousness, the autocratic leadership style, and the fact, prior to our arrival, that there had never been any medical service officers in their armed forces. Furthermore, the medical service officers that we trained, by regulation, would never rise beyond the rank of captain.

In reflecting upon our conversation, I recalled that in several instances I had reinforced and supported the medical leadership's views to the Estado Mayor. Similarly, a month prior to our departure, I had gone to see their Chief of Staff to impress upon him the need to appoint the Director General. This was necessary because we had little time left in country, and a great deal of work remained to be done. On that occasion, in spite of my attempts to avoid it, the Chief of Staff insisted that I state my opinion as to who should be named. After giving a run-down of the major candidates and stating my preference, he agreed, picked up the phone, and directed that appointment orders

be prepared. I also recalled that their armed forces had relied on outside consultation and assistance from the U.S. when they requested that we assess their medical needs shortly after the outbreak of the guerrilla warfare in 1980. They had also requested assistance from our Veterans' Administration for selection of a contractor to equip the new Military Hospital. Likewise, during our tour, we requested an assistance team from the U.S. Army Health Facilities Planning Agency for final evaluations at the new Military Hospital.

As with any system, in any culture, there is always resistance to change; the military medical system in El Salvador is no exception. Hidden agendas, envy, past disagreements, and position rivalries among the military medical leadership created reluctance, on behalf of some, to work together as a team. I had to take a firm stand to force them to sit down with us during the last month and to prioritize for expenditure of funds on needed supplies and equipment. I did so by refusing to release funds until we decided on priorities. Some highly charged unpopular political decisions also met with resistance. At times, I had to press and prod and at other times, back off. In a report of update and observations following MED MTT III, Morales states: "We are no longer as influential in making this happen as the Salvadorans are solidly in control, and their procedures and SOPs must be followed. They do not wish us to be involved in command or policy decisions, and exclude us from conferences dealing with such matters."¹¹⁰

I respectfully, but strongly, disagree with his views. It appears to me, that he encountered the resistance to change of highly charged issues of which I just mentioned. Some important medical issues remain, which will not be resolved until further pressure is applied by our senior medical leadership. These include, among others: recruitment of civilian physicians; advancement of nurses, medical service officers, and enlisted personnel; and pay incentives. The commissioning of civilian physicians has, to date, still not come about inspite of the fact that our unofficial queries suggested that 90% to 95% of civilian residents at the Military Hospital were willing to accept a commission.¹¹¹ These political changes are necessary in order to secure military personnel to effectively run the system. Morales' observations were made six months after my departure, and are at odds with the comments made to me by the Director General ten months after his departure.¹¹²

IX. CONCLUSIONS

We have concluded this exercise persuaded that Central America is both vital and vulnerable, and that whatever other crises may arise to claim the nation's attention the United States cannot afford to turn away from that threatened region. Central America's crisis is our crisis.

-- The National Bipartisan Commission on Central America

In closing, I would like to address three major areas which I think are extremely important. These are: (1) the importance of these types of missions; (2) the need for widespread education of interested parties affected; (3) and, rewards derived from them.

MISSION IMPORTANCE

It has been stated, and echoed by many, that within Low Intensity Conflict (LIC) settings, medical missions of this type are "the least expensive, least controversial, most cost-effective, has the highest pay-off of all instruments of foreign policy."¹¹² I couldn't agree more. Humanitarian aid of this nature appeals to U.S. public opinion and to our Congress, because it is regarded as a noble act which is charitable and worthwhile. It appeals to our collective mentality because it does not contribute to our government's image as being "war

mongers" who are contributing to the killing of people. Rather, it portrays us as saving lives during the ravishes and adversities of armed confrontation. That U.S. public sentiment is not opposed to these types of activity in the civilian area is evidenced by the decades of successful achievement through the U.S. Agency for International Development, the Peace Corps, the medical contributions of U.S. based religious and missionary groups, the efforts of U.S. and international medical disaster relief organizations, and numerous other Volunteer Agencies (VOLAGS).¹¹³

Nor do allied countries engaged in LIC have much opposition to this type of U.S. involvement.¹¹⁴ On the other hand, it allows them to develop capabilities to treat their casualties and reduce morbidity and mortality. This improves morale and confidence of their soldiers that, if wounded, they will receive care. On the other hand, it provides them with measures that will serve as a "force multiplier" by allowing them to more rapidly return to duty those who otherwise would have not been able to do so. The insurgents in El Salvador have recognized the importance of these medical dividends. So much so, it is believed that on a number of occasions, they have infiltrated the medical training for combat medics. It was not unusual for a few trainees to disappear one or two days prior to the conclusion and graduation of a combat medic course.¹¹⁵

While our involvement in programs to build up host-country capabilities is critical, it is also important that we be careful

in how we go about doing so. As tempting as it would be for us to come in as the experts and take over, if we do so, we will undermine the host-country's image. By taking over, we would be reinforcing the image of inadequacy, incompetence, and incapacity of the government forces' ability to care for their own, in the eyes of their own people. That is one of the reasons why we refrained from conducting Medical Civic Action programs which would have made us look good and made them look bad.

By design, in all aspects of our involvement, our intent was to train host-country personnel so that they could take over and be less dependent on us. While it is important that the people acquiring new skills and capabilities develop a sense of confidence and competence in their own abilities, it is also important that we contribute to promoting that sense of trust and confidence among their leadership, their government, and their people.

Involvement in operational medicine issues also pays dividends in regards to its contributions to our own medical readiness. Since the end of the Viet Nam War, the experience within our system on the conduct of medical operations during wartime is relegated to a small number among our dwindling senior officer and noncommissioned officer leadership. Even though we have been medically involved in Honduras, our mission there is quite different from that in El Salvador. The LIC setting in El Salvador is a fertile training ground from which our combat medics and field sanitation/preventive medicine enlisted

specialists could continue to gain. At this stage, the setting could afford excellent training opportunities in the treatment and rehabilitation of combat casualties. The latter is particularly relevant in the fields of general surgery, maxillofacial surgery, head and neck surgery, thoracic surgery, peripheral vascular surgery, orthopedics, hand surgery, plastic surgery, physical medicine, physical therapy, occupational therapy, psychiatry, and psychology. Unlimited opportunities also continue to exist for preventive medicine and environmental science officers.¹¹⁶

Finally, our involvement is also important with regards to the secondary "spill-over" benefits to the general population. By assisting the military medical system, an externality is derived from the indirect training of the part-time civilian physicians and nurses, upon whom the military medical system depends. This was evidenced by the numerous attendance of civilian medical personnel to the Medical Surgical Congress we helped organize and in which most of the keynote speakers were U.S. military physicians.

EDUCATIONAL EFFORTS

The likelihood of U.S. involvement in LIC scenarios is regarded to be extremely high.¹¹⁷ The probability of the inclusion of medical personnel within these types of operations is also regarded as very high.^{118,119} Because these probabilities are so high, and because of the enormous contributions that a

medical mission could make to the success of these efforts, it is extremely important that we educate many sectors about the nature and importance of these medical missions.

Among the most important segments of our population that need to be enlightened is the general public. This effort is required because of the almost immediate and "reflex" reluctance and repulsiveness with which our people regard possible military involvement in the domestic affairs of governments experiencing conflict. Whether justified or not by our unpopular involvement in the Viet Nam War, our nation has a tendency to refrain from active participation unless it is absolutely justified and it is a last ditch effort. Some insights into our collective sentiment are clearly portrayed by the following excerpts:

The 1970s were characterized by an inverse relationship between Soviet growth and American decline in capacity to project power and employ it in low-intensity conflicts. The most frequently cited reason for this American disinclination to employ the military power is attributed to the disillusionment resulting from our Vietnam experience. This frustration led to a revulsion within the American regime toward extending power and employing force in international politics, overturning a foreign policy consensus which had existed since the second world war. It is to these "lessons of Vietnam" and the constraints they have placed on U.S. foreign and defense policy that we now turn . . . ¹²⁰

. . . American military intervention continues to weigh heavily on the minds of important political

actors, as well as on the general public. This has most recently been apparent in the growing opposition to U.S. involvement in El Salvador.¹²¹

Our approach to the "Cubas", "Nicaraguas", and other insurgency settings are illustrative of this national policy. It reflects the threads which weave themselves throughout our national fabric. It reflects how we are wired together as a nation and how our system operates.

Unfortunately, it is a "Catch-22" mentality. By the time the required evidence to justify our involvement is unsurmountable, our intervention may be either too costly, too late, ill-advised, or not worth the effort.

McColm has expressed that:

For a variety of reasons, Americans tend to shy away from a geopolitical framework of analysis. The danger is that the geopolitical lessons relevant to the Caribbean Basin, Central America and Latin America generally will sink in only then when it will be too late to act upon them.¹²²

Our involvement under these circumstances represents the selection of a course of action in a "reactive" rather than a "proactive" mode. The Bipartisan Commission gained insight into this dilemma:

The deterioration in Central America has been such that we cannot afford paralysis in defending our national interests and in achieving our national purposes. The

fact that such paralysis resulted from the lack of a national consensus on foreign policy in the United States would not mitigate the consequences of failure. We believe that a consensus is possible, and must be achieved, on an issue of such importance to the national security of the United States.¹²³ . . . Designing a set of policies which can command bipartisan backing in the United States is thus an essential foundation for diplomatic strategy. Without such support, we risk being mired in uncertainty, and caught up constantly in emergency assessments of what is politically possible in the United States rather than what is diplomatically attainable in Central America.¹²⁴

Our public and our leaders could benefit from an analogy of the dilemmas facing modern medicine today. It is the difference between investing in order to "cure" as opposed to investing in order to "prevent." It is the difference between a "technological" or "surgical" approach, as opposed to a "preventive medicine" approach. It is the difference between "reactive" versus "proactive." In the "technological" approach, our medical research efforts are focused upon the development of glamorized "halfway technologies" such as the artificial heart, renal dialysis, coronary artery bypass surgery, and single or multiple organ transplantation. These technological developments are complex, dramatic, extremely expensive, available to few, and usually too late to alter the course of diseases in the general population. By contrast, the "preventive" approach focuses medical research efforts upon the development of vaccines, medical education programs, and health

promotion initiatives which reduce or eliminate the needs for "halfway" technologies. These efforts are more simple, low key, cheaper, available to many, and timely enough to make the investment worthwhile. Our people need to know that early interventions, including military ones, designed to help satisfy some of the basic medical, social and economic needs of underdeveloped countries in turmoil, can pay off handsomely and reduce the eventual price tag we will, in the long run, have to pay.

We also need to educate our senior military and political leadership about the fact that one of the best ways of overcoming our national apathy towards military involvement might well be through humanitarian military medical efforts. By having a strong military medical investment, our military presence might become more palatable and tolerable to our public sentiment.

Similarly, we must impress upon host countries involved in LIC that, by supporting missions designed to boost their military medical capabilities, they are also boosting morale, confidence in their own capabilities, and their own combatant forces through the "force multiplier" effects of rapid return to duty of combat casualties who would otherwise be lost.

If we accept the role of military medical efforts as desirable and important, then we must educate the leaders within our military structure who can make these efforts a reality. We must impress upon them the need to do a better job of identifying, preparing, and providing support to personnel

designated to carry out these missions. We need to select and screen personnel far in advance, and to identify backup personnel who, on short notice, can serve as replacements for those scheduled to deploy.

On a more long-term basis, we need to establish programs for medical Foreign Area Officers or Medical Regional Experts, who will supply individuals responsible for the mission planning, training of personnel, and participation in directing, leading, and executing different tasks within a given geographic region.¹²⁵ We must also incorporate lectures, written subject matter, and audiovisual materials into the curricula of some of our formal military educational courses (e.g., Officer Advanced Course, Command and General Staff College, War College, Sergeants Major Academy, Advanced NCOES, and others).¹²⁶

REWARDS

My assignment to El Salvador, as Team Chief of Medical MTT II, has been one of the most gratifying, rewarding, and challenging experiences I have had in over 19 years of active duty. It has certainly been the most unforgettable. It was highly challenging and at times scary.

I will always cherish the fond memories of knowing that we accomplished a great deal in a very short time. I will savor with satisfaction the knowledge that we were involved in a meaningful endeavor where our efforts and contributions led to outcomes that altered life and death consequences for a large

number of human beings. The assignment gave us the chance to experience the genuine appreciation of a government and a people who were truly grateful of the assistance we provided.

On a more selfish note, this assignment afforded me the "hands-on" opportunity to acquire personal growth and maturity, and to gain confidence in my leadership abilities by forcing me to make tough decisions and recommendations.

Lastly, this assignment provided me with a chance to lead an outstanding group of young men who approached the mission with maturity, professionalism, and commitment. They banded together as a team and displayed camaraderie, cohesion, loyalty, optimism, and a "can-do" attitude. I am grateful to this fine group who contributed to this memorable learning opportunity. Had their attitudes, behaviors and capabilities not been so outstanding, this paper might well have taken a very different slant.

FOOTNOTES

¹Call Up Message, 18 November 1983, p.2, TAB A.

²AMEDD LIC Study, 12-23 September 1983, MG W.P. Winkler, MC, USA Study Group Leader cited by J.P. Sanford, M.D. "Medical Aspects of Low Intensity Conflict," in a paper presented at the 2nd Annual Military Medical Symposium, October 6-7, 1986, Uniformed Services University of Health Sciences, Bethesda, MD., p.1.

³Ibid, p.4

⁴U.S., Department of State, Bureau of Public Affairs, Background Notes: El Salvador, February 1981, p.3.

⁵General Wallace H. Nutting, "A World in Conflict" Defense 83, December 1983, p.2

⁶U.S., Department of State, Bureau of Public Affairs, Background Notes: El Salvador, February 1981, p.1.

⁷El Salvador: The Near Pacific, El Salvador Tourist Commission, undated, p.4.

⁸U.S., Department of State, Bureau of Public Affairs, Background Notes: El Salvador, February 1985, p.1.

⁹U.S., Department of State, Bureau of Public Affairs, Background Notes: El Salvador, February 1981, p.3.

¹⁰El Salvador: The Near Pacific, El Salvador Tourist Commission, undated, p.5.

¹¹Comparison of Background Notes: El Salvador 1981, p.1, and 1985, p.1.

¹²U.S., Department of State, Bureau of Public Affairs, Background Notes: El Salvador, February 1985, pp.1,3.

¹³Personal observations and conversations with host country nationals.

¹⁴U.S., Department of State, Bureau of Public Affairs, Background Notes: El Salvador, February 1981, p.1,2.

¹⁵Ibid, p.2.

¹⁶U.S., Department of State, Bureau of Public Affairs, Background Notes: El Salvador, February 1985, p.1.

¹⁷Ibid, p.3.

¹⁸Andrew W. Nichols, M.D., M.P.H., Health Sector Policy and Program Review, AID/El Salvador, October 15, 1984, rev. ed. December 15, 1984, (University Research Corporation) p.13.

¹⁹U.S., Department of State, Bureau of Public Affairs, Background Notes: El Salvador, February 1985, p.1.

²⁰U.S., Department of State, Bureau of Public Affairs, Background Notes: El Salvador, February 1981, p.2.

²¹El Salvador: The Near Pacific, El Salvador Tourist Commission, undated, p.7.

²²U.S., Department of State, Bureau of Public Affairs, Background Notes: El Salvador, February 1985, p.3.

²³Ibid.

²⁴U.S., Department of State, Bureau of Public Affairs, Background Notes: El Salvador, February 1981, p.2.

²⁵NBC, "Whatever Happened to El Salvador?" (Circa August 1982, videotape) Bonnie Anderson, Robert Rogers, Richard Valeriani.

²⁶Lydia Chavez "El Salvador: The Voices of Anguish in A Bitterly Divided Land" The New York Times Magazine, December 11, 1983, p.79.

²⁷NBC, "Whatever Happened to El Salvador?" (Circa August 1982, videotape) Bonnie Anderson, Robert Rogers, Richard Valeriani.

²⁸U.S., Department of State, Bureau of Public Affairs, Background Notes: El Salvador, February 1985, p.3

²⁹Shirley Christian, "El Salvador's Divided Military: Are We Supporting Murderers or Reformers?" The Atlantic Monthly, June 1983, p.52.

³⁰U.S., Department of State, Bureau of Public Affairs, Background Notes: El Salvador, February 1985, p.3.

³¹Richard J. Meislin, "Seeker of Reconciliation; Jose Napoleon Duarte," The New York Times Magazine (December 8, 1984).

³²Shirley Christian, "El Salvador's Divided Military: Are We Supporting Murderers or Reformers?" The Atlantic Monthly, June 1983, p.52.

³³U.S., Department of State, Bureau of Public Affairs, Background Notes: El Salvador February 1985, p.3.

³⁴Ibid.

³⁵Shirley Christian, pp.50-60. An excellent account of the role of the military throughout El Salvador's political history is presented in this article. It covers the 1932 peasant uprising, the partnership between the military and the oligarchy, graft and corruption, Duarte's 1972 election victory, and the problems of the judicial system.

³⁶Edward Cody, "Respect Vote, Salvadoran Army Told" Washington Post (May 5, 1984).

³⁷U.S., Department of State, Bureau of Public Affairs, Background Notes: El Salvador, February 1985, p.3.

³⁸Ibid.

³⁹Message from Secretary of State, Unclassified, March 18, 1984, Subject: Briefer for Salvadoran Elections.

⁴⁰U.S., Department of State, Bureau of Public Affairs, Background Notes: El Salvador, February 1985, p.3.

⁴¹Ibid.

⁴²Ibid, p.4.

⁴³Almost all data and information in this section have been extracted and summarized from U.S. Department of State, Bureau of Public Affairs, Background Notes: El Salvador; February 1981 and February 1985.

⁴⁴Henry A. Kissinger, Chairman, Report of The National Bipartisan Commission on Central America, Washington, D.C., January 10, 1984, p.28.

⁴⁵Personal communications with U.S. Embassy and other U.S. personnel.

⁴⁶U.S., Department of State, Bureau of Public Affairs, Background Notes: El Salvador, February 1985, p.7.

⁴⁷Personal communications with U.S. MILGP personnel.

⁴⁸Shirley Christian.

⁴⁹Personal communications and observations.

⁵⁰U.S., Department of State, Bureau of Public Affairs, Background Notes: El Salvador, February 1985, p.8.

⁵¹Reprint of GIST (July 1983) Contained in "El Salvador: Certification Process," The DISAM Journal of International Security Assistance Management vol. 6, no.1, Fall 1983, p.60.

⁵²Kissinger, p.27.

⁵³Ibid, pp.23-24.

⁵⁴Ibid, p.81.

⁵⁵Joan Didion, Salvador (New York, Simon and Schuster, 1983), p.82.

⁵⁶NBC, "Whatever Happened to El Salvador?" (Circa August 1982, videotape) Bonnie Anderson, Robert Rogers, Richard Valeriani.

⁵⁷The foreign communist support to insurgents has been amply documented in the unclassified military, governmental and journalistic literature. An extensive review of this support is beyond the scope of this paper. An excellent summary is presented in Report No. 80, "Communist Interference in El Salvador," (United States Department of State, Bureau of Public Affairs, Washington, D.C., February 23, 1981), pp.1-9.

⁵⁸Foreign communist intervention is also amply documented in Kissinger, pp.25-28, 84-101.

⁵⁹NBC, "Whatever Happened to El Salvador?" (Circa August 1982, videotape) Bonnie Anderson, Robert Rogers, Richard Valeriani.

⁶⁰Shirley Christian, p.60.

⁶¹U.S., Department of State, Bureau of Public Affairs, Background Notes: El Salvador, February 1985, p.6.

⁶²Kissinger, p.104.

⁶³Ibid, p.4.

⁶⁴Ibid, p.107.

⁶⁵Andrew W. Nichols, M.D., M.P.H., Health sector Policy and Program Review, AID/El Salvador, October 15, 1984, rev. ed. December 15, 1984, (University Research Corporation), pp. 17-170.

⁶⁶Gerald A. Faich and Robert Coppedge; Assessment Report Emergency Medical Services; El Salvador April-May 1983, (U.S. Agency for International Development ADSS AID/DSPE-C-0053), pp. 3-17.

⁶⁷Personal communication with COL Rodolfo Giron-Flores, Director, Military Hospital.

⁶⁸Andrew W. Nichols, M.D., M.P.H., Health Sector Policy and Program Review, AID/El Salvador, October 15, 1984, rev. ed. December 15, 1984, (University Research Corporation), (Nichols), p.52.

⁶⁹Ibid., and Nichols p.22

⁷⁰Ibid, p.22.

⁷¹Colonel Hernan Morales, MC, USA "After Action Report Medical Survey Team: El Salvador," August-September, 1980, Unpublished, pp.1-31 (TAB D-1).

⁷²Edward F. Lynch, "Report of Medical Service Staff Visit, 20-25 March 1983," pp.1-6.

⁷³Colonel Robert F. Elliott, Memorandum for Secretary of Defense, 7 September 1983, subject: Medical MTT Objectives and MEDEVAC Requirements, TAB D-1.

⁷⁴Colonel Hernan Morales, After Action Report Medical Survey Team: El Salvador, August-September, 1980, Unpublished, pp.1-31 (TAB B).

⁷⁵Elliott.

⁷⁶Briefing to Med MTT II, on February 1984, by Colonel Adelio Quinteros, Director of Military Hospital.

⁷⁷Personal communications and observations.

⁷⁸The information regarding the military medical scenario was obtained from personal communications and observations, predeployment briefings and documents prepared by Med MTT I. Among the documents are the After Action Report on Effectiveness of Training (TAB D-1), Team Chief Observations (TAB D-2), and Recommendation and Comments (TAB D-3).

⁷⁹Extracted from Memorandum for Secretary of Defense. Data were based upon figures released by the Ministry of Defense of El Salvador, cited by Edward Cody, "Death Toll Doubles in El Salvador: Defense Minister Reports Casualties of 6,815 in Year," Washington Post, August 12, 1983, pp.1A-12.

⁸⁰The accuracy and validity of casualty and survival figures are questionable because of the lack of a sophisticated reporting system. However, they are the best information available.

⁸¹Colonel Paul R. Meyer, Jr., "After Action Report" USMILGP MED MTT V, El Salvador, 13 August-13 September 1985, pp.1-37.

⁸²Ibid, p.3.

⁸³Ibid, p.6.

⁸⁴From: Report on the Effectiveness of Training, U.S. Army Humanitarian Medical MTT El Salvador (Phase I, 23 May-19 December 1983, dated 20 January 1984.

⁸⁵From: Report on the Effectiveness of Training, U.S. Army Humanitarian Medical MTT II El Salvador (Phase I, 23 May-19 December 1983, dated 17 August 1984.

⁸⁶Doc Fitz, Civic Action Central America; Activities 1984 Air Commando Association, Inc., Newsletter, February, 1985, p.16.

⁸⁷Personal observations and communications.

⁸⁸This subject is addressed at length by Shirley Christian, pp.50-60.

⁸⁹Colonel Rodolfo Giron Flores, the Director of the Military Hospital was a prime example of integrity. Upon assuming command of the Military Hospital, he began to do away with some of the perks that the medical officers had traditionally enjoyed. In fact, he explored with us the possibility of incorporating the Military Hospital's budget into the Security Assistance Program, under our supervision, in order to minimize the possibilities of rake-offs and kickbacks within their system.

⁹⁰Personal communications and observations.

⁹¹Personal communications with Colonel Marco Antonio Marchan, Commander, Military Medical Battalion.

⁹²Meyer, p.27, documented and further amplified on the plight of the MSC officer.

⁹³Personal observations and communications.

⁹⁴Personal observations and communications.

⁹⁵Colonel Hernan Morales, M.D. in "Salvadoran Military Medical Update and Observations as to Future Operations, January 25, 1985, unpublished document. (TAB D-4).

⁹⁶A discussion on the drawbacks of "cosmetic measures" is found in Major Donald J. Bruss' article on "The Changing Role of the Army Medical Department in Low Intensity Conflict," unpublished draft, February 29, 1984, pp.17-18, 25-26.

⁹⁷Morales reported that their original projections were premature and unrealistic and that they should be discarded (see TAB D-4, p.9).

⁹⁸Ibid, p.7. Morales agreed on the need to adhere to the chain of command under the USMILGP.

⁹⁹Ibid, p.8. Other MTTs experienced similar problems for identifying suitable personnel.

¹⁰⁰From: a paper by LTG Paul F. Gorman, "Low Intensity Conflict, Not Fulda, Not Kola, June 7, 1984, p.62 (Included as Reading 7 in the Report of the National Bipartisan Commission on Central America, 85-(RC 100-39)-1196.

¹⁰¹General John A. Wickham, USA, "Continuity and Change: Tempering Army of the '80's," in the Army 1983-84 Green Book, published by AUSA, October 1983, pp.18-24.

¹⁰²General Edward C. Meyer, USA, "Low-Level Conflict: An Overview," from Terrorism and Beyond: An International Conference on Terrorism and Low-Level Conflict, December 1982, (The Rand Corporation), pp.38-42.

¹⁰³Morales pointed out similar problems faced by non-Spanish speaking members of Med MTT III (See TAB D-4, p.5).

¹⁰⁴According to some of the people with whom I spoke, the absence of blacks was something that was determined by law. I was told that when General Maximiliano Hernandez Martinez was in power, he passed a law decreeing that if a Salvadoran citizen married a black, they had to resign their citizenship, or leave the country. This law was supposedly repealed when the Constituent Assembly was created in 1982. Consequently, the few blacks in country, unassociated to the U.S., were either basketball or soccer players.

¹⁰⁵John Weisman, "Why TV is . . . Missing the Picture in Central America?" Special Report, TV Guide, September 15, 1984.

¹⁰⁶Morales, p.29.

¹⁰⁷Lynch, p.5.

¹⁰⁸Elliott.

¹⁰⁹Personal communication with Colonel Rodolfo Giron Flores, November 1985.

¹¹⁰Morales, p.4.

¹¹¹Personal observations and communications.

¹¹²Personal communication with Colonel Rodolfo Giron Flores, November, 1985.

¹¹³Bruss, pp.14-16.

¹¹⁴Bruss, p.9 citing Dr. Martin E. Silverstein and Ambassador David Newson who, in March 1983, presented a seminar on "Health as an Instrument of Foreign Policy." (Seminar: "Health as a Foreign Policy Instrument," Silverstein, Martin E., and Newson, David D., Center for Strategic and International Studies, Georgetown University, Washington, D.C., March 1, 1983).

¹¹⁵Personal observations and communications.

¹¹⁶Meyer, p.5, has recommended consideration of opportunities for limited postgraduate training in preventive medicine, infectious disease, pediatrics, orthopedic surgery, and cardiac surgery.

¹¹⁷This likelihood has been documented in the chapter of Lessons Learned.

¹¹⁸AMEDD-LIC Study cited by Sanford, p.1.

¹¹⁹LTG Paul F. Gorman, pp.66-67.

¹²⁰Richard Shultz, "Low Intensity Conflict and American Strategy in the 1980's," Conflict Quarterly, Winter 1982, p.13.

¹²¹Ibid, p.20.

¹²²McColm, Bruce R., "Central America and the Caribbean: The Larger Scenario, Strategic Review, Vol XI, No.3, Summer 1983, p.29.

¹²³Kissinger, p.105.

¹²⁴Ibid, p.107.

¹²⁵Bruss, pp.54-60.

¹²⁶LTC Brian Chermol, Deputy Team Chief of MED MTT II and MED MTT III prepared a "storybook" script for a video documentary to orient team members of future MTTs to El Salvador. It was submitted for consideration to the Academy of Health Sciences, Fort Sam Houston, Texas, but the documentary has never been filmed (see TAB F).

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